

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155727	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 06/30/2015
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NAME OF PROVIDER OR SUPPLIER STONEBRIDGE HEALTH CAMPUS	STREET ADDRESS, CITY, STATE, ZIP CODE 3100 SHAWNEE DR S BEDFORD, IN 47421
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F 0000 Bldg. 00	<p>This visit was for a Recertification and State Licensure Survey</p> <p>Survey dates: June 22, 23, 24, 25, 26, 29, and 30, 2015.</p> <p>Facility number: 003924 Provider number: 155727 AIM number: 200472040</p> <p>Census bed type: SNF: 12 SNF/NF: 39 Residential: 32 Total: 83</p> <p>Census Payor type: Medicare: 13 Medicaid: 30 Other: 8 Total: 51</p> <p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2-3.1.</p>	F 0000	The submission of this plan of correction does not indicate an admission by Stonebridge Health Campus that the findings and allegations contained herein are an accurate and true representation of the quality of care provided to our residents of Stonebridge Health Campus. This facility recognizes its obligation to provide legally and medically necessary care and services to its residents in an economic and efficient manner. The facility hereby maintains it is in substantial compliance with the requirements of participation for comprehensive health care facilities. To this end, this plan of correction shall serve as the credible allegation of compliance of this facility. We respectfully request from the department paper compliance. It is thus submitted as a matter of statute only. All corrections have been submitted to this POC.	
F 0225	483.13(c)(1)(ii)-(iii), (c)(2) - (4)			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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SS=D Bldg. 00	<p>INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS</p> <p>The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities.</p> <p>The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency).</p> <p>The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress.</p> <p>The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.</p> <p>Based on interview and record review, the facility failed to ensure staff had</p>	F 0225	Corrective actions accomplished for those	07/30/2015	

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F 0226 SS=D	<p>obtained an annual inservice on abuse, for 1 of 5 employees reviewed for ongoing in-service education and training. (LPN #3).</p> <p>Findings include:</p> <p>On 6/26/15 at 5:00 p.m., a personnel record review was completed. The employee personnel records indicated the following:</p> <p>LPN (Licensed Practical Nurse) #3 began employment on 06/20/2007. Her personnel record lacked documentation which indicated she received annual education and training on resident abuse for 2014, and not yet completed for 2015.</p> <p>On 6/26/2015 at 5:00 p.m., an interview with Clinical Support Staff indicated the facility does not have a policy in regard to annual in-services. At that time, she indicated the annual education had not been completed for LPN #3 for 2014, and had not completed yet for 2015.</p> <p>3.1-28(a)</p> <p>483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT,</p>		<p>residents found to be affected by the alleged deficient practice: 1). No residents were affected. 2). There were no incidents unreported. 3). LPN #3 has received training on Abuse/Neglect and reporting guidelines on 7/20/15 by DHS.</p> <p>Identification of other residents having the potential to be affected by the same alleged deficient practice and corrective actions taken: All personnel files were audited by ADHS for completion of annual abuse/neglect training.</p> <p>Measures put in place and systemic changes made to ensure the alleged deficient practice does not recur: ADHS or designee will maintain log of annual abuse/neglect training for all employees. How the corrective measures will be monitored to ensure the alleged deficient practice does not recur: Employee inservice record audits will be conducted by the ED or designee monthly x 6 months to ensure compliance. These findings will be reviewed quarterly by the QA committee for a duration of 12 months.</p>		

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Bldg. 00	<p>ETC POLICIES</p> <p>The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.</p> <p>Based on interview and record review, the facility failed to ensure implementation of their policy to ensure ongoing abuse inservice education for 1 of 5 employees reviewed for ongoing in-service education and training. (LPN #3).</p> <p>Findings include:</p> <p>On 6/26/15 at 5:00 p.m., a personnel record review was completed. The employee personnel records indicated the following:</p> <p>LPN (Licensed Practical Nurse) #3 began employment on 06/20/2007. Her personnel record lacked documentation which indicated she received annual education and training on abuse for 2014, and not yet completed for 2015.</p> <p>On 6/26/2015 at 5:00 p.m., an interview with Clinical Support Staff indicated the facility does not have a policy in regard to annual in-services. At that time, she indicated the annual education had not been completed for LPN #3 for 2014, and had not yet completed for 2015.</p>	F 0226	<p>Corrective actions accomplished for those residents found to be affected by the alleged deficient practice: 1). No residents were affected 2) LPN #3 has received training on Abuse/Neglect and reporting guidelines per the established Policy and Procedure.</p> <p>Identification of other residents having the potential to be affected by the same alleged deficient practice and corrective actions taken: All personnel files were audited by ADHS for completion of annual abuse/neglect training.</p> <p>Measures put in place and systemic changes made to ensure the alleged deficient practice does not recur: ADHS or designee will maintain log of annual abuse/neglect training for all employees. How the corrective measures will be monitored to ensure the alleged deficient practice does not recur: Employee inservice record audits will be conducted by the ED or designee monthly x 6 months to ensure compliance. These findings will be reviewed quarterly by the QA committee for a duration of 12 months.</p>	07/30/2015	

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F 0246 SS=D Bldg. 00	<p>3.1-28(a)</p> <p>483.15(e)(1) REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES A resident has the right to reside and receive services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered.</p> <p>Based on observation, interview, and record review, the facility failed to ensure a call light was within reach for a resident who was capable of using a call light for 1 random observation (Resident #43) and a resident received ADL (Activities of Daily Living) care according to their personal preferences for 1 of 3 residents reviewed for choices (Resident #55), and residents were allowed to choose their wake time for 2 of 3 residents reviewed for choices (Resident #26 and Resident #71).</p> <p>Findings include:</p> <p>1. On 6/26/15 at 2:38 p.m., Resident #43 was observed asleep in her bed . The call light was positioned at the foot of the bed and tightly tucked underneath a blanket.</p> <p>On 6/26/15 at 2:53 p.m., Resident #43</p>	F 0246	<p>Corrective actions accomplished for those residents found to be affected by the alleged deficient practice: Resident's 26, 55 & 71's personal preferences, including showers and what time they would like to rise, nap and rest have been updated.</p> <p>Resident #43 call light was immediately placed in reach during the survey process.</p> <p>Identification of other residents having the potential to be affected by the same alleged deficient practice and corrective actions taken: All residents have the potential to be affected . All resident preferences have been audited for accuracy by ED, DHS or designee and care plans updated as needed.</p> <p>Measures put in place and systemic changes made to ensure the alleged deficient practice does not recur: DHS or designee will re-educate the</p>	07/30/2015

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	<p>indicated if she needed help she would just push her call light, but she was unsure where her call light was. At that time, LPN #2 was observed to pull the resident's call light out from under the blanket and hand it to the resident. LPN #2 indicated the call light was not within reach and it should be up by her in bed, within reach.</p> <p>On 6/25/15 at 3:39 p.m., Resident #43's clinical record was reviewed. Diagnoses included, but were not limited to: history of urinary retention and colostomy. The quarterly review MDS (Minimum Data Set) assessment, dated 4/24/15, indicated the resident required extensive assistance of 1 with bed mobility.</p> <p>The quarterly review MDS (Minimum Data Set) assessment, dated 4/24/15, indicated Resident #43 had a BIMS (Brief Interview for Mental Status) total score of 5. A score of 0-7 indicated the resident was severely cognitively impaired.</p> <p>A care plan initiated on 5/7/15, with a current goal date through 7/27/15 for Resident #43 indicated a focus of, "ADLS (Activities of Daily Living)... I am at risk for falls... Keep my call light within reach and answer it promptly ..."</p> <p>On 6/29/15 at 2:10 p.m., the ED (Executive Director) provided the "Guidelines for Answering Call Lights,"</p>		<p>Nursing Staff on the following guideline: 1. Bill of Resident's Rights 2. Guidelines for Answering Call Lights 3. Guidelines for Resident Personal Preferences. How the corrective measures will be monitored to ensure the alleged deficient practice does not recur:The following observations will be conducted by the DHS or designee. 1) The DHS/Designee will observe call light placements 2 x daily on all shifts for 1 week, then daily on all shifts for one week, then random checks 3 x week on varying shifts for 5 additional weeks. 2) DHS/Designee will observe that showers/bathing is according to resident preference and plan of care for 5 residents weekly times 5 weeks, then monthly times 5 months to ensure compliance. 3) Choice rise and rest times according to resident preference for 5 residents weekly times 5 weeks, then monthly times 5 months to ensure compliance. These findings will be reviewed quarterly by the QA meeting for a duration of 12 months.</p>				

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	<p>policy, undated, and indicated it was currently being used by the facility. The policy indicated, "... 2. Ensure the call light is ... in reach of the resident. ... 16. ... return the call light to within the reach of the resident."</p> <p>2. On 6/23/15 at 10:54 a.m., Resident #55 indicated she was showered twice a week, but preferred at least three showers a week and cleaned up on all other days. The resident indicated prior to living at the facility she showered daily.</p> <p>Resident #55's clinical record was reviewed on 6/29/15 at 10:47 a.m. Diagnoses included, but were not limited to: history of left hip fracture and Parkinson.</p> <p>A care plan initiated on 5/20/15, with a current goal through 8/20/15, indicated a focus of, "ADLS... My ADL [Activities of Daily Living] self performance fluctuates [sic] r/t [related to] my Parkinson's. ... I would like to be showered at least two times a week and bathed on all other days ..."</p> <p>Resident #55's June 2015, "ADL Detail Report" lacked documentation which indicated the resident was being bathed daily.</p>			

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	<p>During an interview, on 6/20/15 at 12:11 p.m., the DHS (Director of Health Services) indicated Resident #55 was not bathed three times a week as she indicated.</p> <p>On 6/25/15 at 9:45 a.m., the ED (Executive Director) provided the facility's policy, "Bill of Resident Rights," dated 10/2004, and indicated it was the policy currently being used by the facility. The policy indicated, "... Accommodation of Needs: 38. You have the right to reside and receive services in the facility with reasonable accommodation of individual needs and preferences ..."</p> <p>3. Resident #26's clinical record was reviewed on 6/24/2015 at 1:33 p.m. Diagnoses included but were not limited to: depression, gastroesophageal reflux disorder, stroke, left hemiparesis, dysphagia, hypertension, gait ataxia, hypothyroidism, and narcolepsy.</p> <p>On 06/23/2015 at 1:33 p.m. an interview with Resident #26 indicated, she would like to sleep till 8:00 a.m. They come in at 6:00 a.m., and wake her up and won't allow them to lay down during the day.</p> <p>The quarterly Minimum Data Set (MDS) dated 5/7/2015, assessed Resident #26's (BIMS) Brief Interview for Mental Status</p>			

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	<p>score as a 13, a score of 13-15 indicated the resident was cognitively intact and interviewable.</p> <p>Review of the monthly nursing assessment and data collection tools dated from 9/20/2014 through 6/20/2015, indicated the assessments lacked any documentation of assessment for sleep. The assessment tool had a section for sleep to be assessed.</p> <p>Review of conference notes dated 5/21/2015 and 2/19/2015, indicated no documentation of wake time.</p> <p>Review of the Individual Plan Report dated 5/10/2015, for Resident #26 indicated there was no care plan for wake time.</p> <p>On 6/24/2015 at 11:15 a.m., an interview with CRCA #2 (Certified Resident Care Assistant) indicated they start at the back of the hall and work their way forward to get the residents up. She indicated they get report at 5:30 a.m., and start getting residents up at 5:45 a.m., which is Resident #26's room. She goes into the resident's room and touches their arm and asks them if they are ready to get up. If they aren't she lets them continue to sleep. CRCA #2 indicated she did not know what time Resident #26 wanted to</p>			

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	<p>get up in the morning . She reviewed her CNA assignment sheet for the 200 hall and indicated there was no preferences for wake or sleep time on the CRCA sheet.</p> <p>On 6/24/2015 at 11:26 a.m., an interview with CRCA #1 indicated they start at the back of the hall and work their way forward to get residents up. She knocks on the door and lets Resident #26 use the bedpan, helps her to wash, then dresses her in bed and then gets her up if she is ready to get up. Review of the CRCA assignment sheet for the 200 hall indicated Resident #26 preferred to get up at 7:00 a.m. and go to bed at 7:00 p.m.</p> <p>Review of the CRCA sheet for the 200 hall indicated, Resident #26 preferred to get up at 7:00 a.m.</p> <p>On 6/24/2015 at 11:47 a.m., an interview with Activities Director indicated they do a full assessment on admission, significant change of condition, and annually. Progress notes are made quarterly. Residents #26's annual preferences and activities profile completed on 8/20/2014, indicated no documentation for preferences related to morning wake time. He indicated the MDS (Minimum Data Set) assessment section F was used at that time for how</p>			

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	<p>important it was for her choose when she woke in the morning. The assessment did not indicate what time she wanted to get up.</p> <p>On 6/24/2015 at 11:50 a.m., an interview with Activities Director indicated that the preferences sheets for the residents are given to the DHS (Director of Health Services). At that time, he indicated the forms do ask how important things are to the residents but do not ask specific information such as what time do they want to get up.</p> <p>On 6/24/2015 at 2:55 p.m., an interview with the DHS (Director of Health Services) indicated when a preference has been identified for a resident it is placed on the CRCA assignment sheet and/or the care tracker. Review of the CRCA assignment sheet with the DHS indicated Resident #26 wanted to get up at 7:00 a.m., and go to bed at 7:00 p.m.</p> <p>On 6/24/2015 at 2:50 p.m., the Director of Health Services provided the Guidelines for Resident Personal Preferences and Profile policy dated 5/2012, and indicated the policy was the one currently being used by the facility. The policy indicated the following: "Purpose: To provide guidelines obtaining resident</p>			

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	<p>personal preferences and including them in the care planning process.</p> <p>Procedure:</p> <ol style="list-style-type: none"> The Nursing Staff shall discuss the resident's preferences for sleep/wake times and bathing as part of the admission assessment process This information shall be used to wake the resident in the morning... The resident preferences and other care plan interventions shall be entered into the Resident Profile in the Care Tracker system by a member of the nursing leadership team for communication to nursing assistants. The resident preferences and expectations for care and services shall be...updated as indicated in further meetings... The preferences shall be included in the resident's plan of care to ensure it is reflective of their interests and choices." Resident #71's clinical record was reviewed on 6/24/15 at 11:03 a.m. The diagnosis included, but were not limited to:osteoarthritis, hypertension and cerebral atrophy (disease that affects the brain). <p>The current quarterly Minimum Data Set (MDS) assessment dated 5/8/15, indicated a Brief Interview of Mental Status score of 15, which indicated interviewable and cognitively intact.</p>			

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	<p>Resident #71 required extensive assistance of 1 staff person for bed mobility.</p> <p>Review of the "Life Enrichment Assessment" form dated 4/8/15, indicated "...E. What are your usual sleep patterns? early to bed, late riser. ..."</p> <p>Review of "Nursing Admission Assessment & Data Collection tool" form dated 4/1/15 indicated, " ... Sleep: ... Naps during day ..." The assessment form lacked documentation of when Resident #71 would like to awake in the morning.</p> <p>Careplan Activity of Daily Living dated 6/23/15, lacked documentation of when Resident #71 would prefer to get up in the morning.</p> <p>On 6/23/15 at 9:23 a.m., Resident #71 indicated,"They [indicating staff] get me up at 6:00 a.m. I would like to sleep until 8:00 a.m." Resident #71 indicated she had not told staff, but staff never asked her. Staff would come into Resident #71's room and get Resident #71 up.</p> <p>On 6/24/2015 at 11:15 a.m., an interview with CRCA (Certified Resident Care Assistant) #2 indicated they (CRCA's) start at the back of the hall and work their</p>			

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	<p>way forward to get the residents up. CRCA #2 indicated they (indicating CRCA's) get report at 5:30 a.m., and start getting residents up at 5:45 a.m. She goes into the resident's room, touches their arm and asks them if they are ready to get up. If they aren't she lets them continue to sleep. When asked when Resident #71 wanted to get up in the morning CRCA #2 indicated she didn't know. CRCA #2 reviewed her CNA assignment sheet and indicated there was no preferences for wake time on the CRCA sheet. Resident #71 was usually awoken at 6:00 a.m.</p> <p>On 6/24/2015 at 11:26 a.m., an interview with CRCA #1 indicated they start at the back of the hall and work their way forward to get residents up.</p> <p>Review of the CRCA assignment sheet for the 200 hall indicated there was no preferences for awake time for Resident #71.</p> <p>On 6/24/2015 at 11:47 a.m., an interview with the Activities Director indicated that you do a full assessment on admission, significant change of condition, and annually. Progress notes are made quarterly. The form that was used at that time only used the MDS section F for how important it was for Resident #71 to</p>			

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F 0279 SS=D Bldg. 00	<p>get up. The Activities Director indicated that the preference sheets for the residents are given to the Director of Health Service (DHS). The Activity Director indicated the forms do ask how important things are to the residents but do not ask specific information such as what time do they want to get up.</p> <p>On 6/25/15 at 9:54 a.m., the Executive Director provided policy "BILL OF RESIDENT RIGHTS" dated 10/2004, and indicated the policy was the one currently used by the facility. The policy indicated, "...Quality of Life: ... 35. You have the right to: a. Choose ... schedules, ...consistent with your ...plans of care. ... c. Makes choices about aspects of your life in the nursing facility that are significant to you. ... Accommodation of Needs: 38: You have the right to ... receive services in the facility with reasonable accommodation of individual needs and preferences, ... "</p> <p>3.1-3(v)(1)</p> <p>483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.</p>			

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	<p>The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.</p> <p>The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).</p> <p>Based on interview and record review, the facility failed to ensure Resident's careplan was developed after assessment for resident prescription of antipsychotic medication for exhibited behaviors of delirium and paranoia for 1 of 5 resident reviewed for unnecessary medication use (Resident #89), and a careplan was revised as the facility policy indicated for 1 of 1 residents reviewed for hydration (Resident #69).</p> <p>Findings include:</p> <p>1. Resident #89's clinical record was reviewed on 6/24/15 at 2:49 p.m. Diagnosis included, but were not limited to: acute delirium and paranoia.</p> <p>Resident #89 was admitted to the facility</p>	F 0279	<p>Corrective actions accomplished for those residents found to be affected by the alleged deficient practice: Resident #89 & # 69 care plans were revised and corrected to reflect current orders. Identification of other residents having the potential to be affected by the same alleged deficient practice and corrective actions taken: DHS or designee will review residents receiving antipsychotic medications and/or on an altered diet to ensure a care plan is in place for each. Measures put in place and systemic changes made to ensure the alleged deficient practice does not recur: DHS/Designee will review all orders daily in the am clinical meeting and ensure care plan is updated accordingly. How the</p>	07/30/2015

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	<p>on 12/31/14.</p> <p>The current admission comprehensive Minimum Data Set assessment (MDS) dated 1/7/15, lacked documentation Resident #89 had a diagnosis for use of an antipsychotic and there was no psychotic disorder indicated. The behavioral symptoms had indication Resident #89 had behaviors not directed toward others.</p> <p>Review of the facilities Behavior Detail Report, indicated the following:</p> <p>On 4/14/15, Resident #89 kicked at staff with care.</p> <p>On 4/22/15, Resident #89 was verbally abusive and physically abusive.</p> <p>On 4/29/15, Resident #89 was verbally abusive.</p> <p>On 5/2/15, Resident #89 was verbally abusive.</p> <p>On 5/16/15, Resident #89 was verbally abusive.</p> <p>On 5/23/15, Resident #89 was verbally abusive.</p> <p>On 5/29/15, Resident #89 was socially</p>		<p>corrective measures will be monitored to ensure the alleged deficient practice does not recur: The following audits will be conducted by the DHS or designee on 5 residents weekly for 5 weeks then monthly times 5 months to ensure compliance: 1. All orders were reviewed, 2. Determine if there were any changes to the orders, 3. Ensure the care plan was updated The results of the observations will be reported, reviewed and trended by the ED for compliance thru the daily Clinical Meetings. These findings will be reviewed quarterly by the QA committee for a duration of 12 months.</p>		

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	<p>inappropriate behavior/other.</p> <p>On 6/1/15, Resident #89 was verbally abusive.</p> <p>On 6/3/15, Resident #89 was verbally abusive.</p> <p>On 6/8/15, Resident #89 was physically abusive.</p> <p>On 6/14/15, Resident #89 was physically abusive.</p> <p>On 6/24/15, Resident #89 was verbally abusive.</p> <p>Physician's orders dated 2/17/15, indicated Resident #89 to receive Risperdal 0.25 mg at hour of sleep for 14 days. On 3/6/15, physician's order indicated Resident #89 received Risperdal 0.25 mg twice a day</p> <p>The clinical record lacked documentation of a care plan for the use of antipsychotic medication.</p> <p>On 6/26/15 at 9:45 a.m., the (MDS) Minimum Data Set coordinator indicated, "Normally we would have one for that [indicating a care plan for antipsychotic medication]." The MDS coordinator indicated there was no care plan</p>			

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	<p>completed for antipsychotic use.</p> <p>On 6/25/15 at 9:56 a.m., the Executive Director provided policy "GUIDELINES FOR CARE PLAN DEVELOPMENT" dated June 2013, and indicated the policy was the one currently used by the facility. The policy indicated, "...4. A care plan shall be developed no later than 21 days after admission, and no later that 7 days MDS triggers, diagnoses, risk factors and other applicable care needs. ..."</p> <p>2. On 6/24/2015 at 1:51 p.m., Resident #69 was observed asleep in bed. His lips and oral mucosa were dry and pale. No water was observed at the bedside. Resident #69 was making an involuntary, twitching motion while asleep.</p> <p>On 6/25/2015 at 9:44 a.m., Resident #69 was observed lying in bed asleep. His lips and oral mucosa were dry and pale, with a white crusty substance observed in the back of his throat and on his tongue. No water was observed at the bedside.</p> <p>Resident #69's clinical record was reviewed on 6/25/2015 at 10:00 a.m. Diagnoses included, but were not limited to Parkinson's disease and cardiomyopathy.</p> <p>The current Minimum Data Set (MDS) dated 5/27/2015, indicated a Brief</p>			

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	<p>Interview Mental Status (BIMS) score of 6, with 6 being non-interviewable with severe cognitive impairment. The current MDS further assessed Resident #69 as needing setup help with eating.</p> <p>Physician's order dated June 19, 2015 indicated, "Reduce diet from regular textures/thin liquids to mechanical soft diet excluding breads and nectar thick liquids with no straws." An order dated June 24, 2015 indicated, "Speech Therapy (ST) diet clarification order: mechanical soft diet, no breads, nectar thick liquids, no straws."</p> <p>A careplan initiated on 5/29/2015, with current goal date through 8/28/2015, for Resident #69 indicated a focus of: "... SKIN: I am at risk for dehydration related to my diagnoses and I take a diuretic medication ... Keep fresh water at my bedside ..."</p> <p>A careplan for Resident #69 initiated on 5/29/2015, with current goal date through 8/28/2015, indicated a focus of: "... BOWEL AND BLADDER: ... I want fresh drinking water at my bedside, at least, once per shift ..."</p> <p>On 6/24/2015 at 2:46 p.m., an interview with Certified Resident Care Assistant #4 (CRCA) indicated, Resident #69</p>			

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	<p>currently had an order for thickened water and the Director of Nursing (DON) had told her not to leave thickened water at the bedside.</p> <p>06/24/2015 2:47 p.m., an interview with CRCA #5 indicated, Resident #69 is not allowed to have thickened water at the bedside and the residents wife was just asking the last time she was in why the resident did not have water.</p> <p>On 6/24/2015 at 2:56 p.m., an interview with the Director of Nursing indicated, Resident #69's condition changed Friday, June 19, 2015; and the speech therapist ordered thickened water after her evaluation. It is my personal policy not to leave thickened water at the bedside, because bacteria can grow at room temperature however, the care plan had not been updated and there was no order indicating water should not be left at the bedside. The DON indicated the care plan should have been updated on Monday, June 22, 2015, but it had not been. She will get that done as soon as possible.</p> <p>On 6/30/2015 at 11:450 a.m., the Administrator provided the facility's policy, "Policy Interpretation and Implementation". The policy indicated, "...4. ... Changes in the resident's</p>			

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F 0282 SS=D Bldg. 00	<p>condition must be reported to the Registered Nurse (RN) Assessment Coordinator so that a review of the resident's assessment and care plan can be made. ..."</p> <p>3.1-35(a)</p> <p>483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. Based on observation, interview, and record review, the facility failed to ensure staff followed residents' care plans as the facility policy indicated to ensure a call light was within reach for a resident who was capable of using a call light for a resident (Resident #43) and water was provided at the bedside for a resident (Resident #69).</p> <p>Findings include:</p> <p>1. On 6/26/15 at 2:38 p.m., Resident #43 was observed asleep in her bed. The call light was positioned at the foot of the bed and tightly tucked underneath a blanket.</p>	F 0282	<p>Corrective actions accomplished for those residents found to be affected by the alleged deficient practice: Resident #89 & # 69 care plans were revised and corrected to reflect current orders. Identification of other residents having the potential to be affected by the same alleged deficient practice and corrective actions taken: DHS or designee will review residents receiving antipsychotic medications and/or on an altered diet to ensure a care plan is in place for each. Measures put in place and systemic changes made to ensure the alleged deficient practice does not</p>	07/30/2015

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	<p>On 6/26/15 at 2:53 p.m., Resident #43 indicated if she needed help she would just push her call light, but she was unsure where her call light was. At that time, LPN #2 was observed to pull the resident's call light out from under the blanket and hand it to the resident. LPN #2 indicated the call light was not within reach and it should be up by her in bed, within reach.</p> <p>On 6/25/15 at 3:39 p.m., Resident #43's clinical record review was reviewed. Diagnoses included, but were not limited to: history of urinary retention and colostomy. The quarterly review MDS (Minimum Data Set) assessment, dated 4/24/15, indicated the resident required extensive assistant of 1 with bed mobility.</p> <p>The quarterly review MDS (Minimum Data Set) assessment, dated 4/24/15, indicated Resident #43 had a BIMS (Brief Interview for Mental Status) total score of 5. A score of 0-7 indicated the resident was severely cognitively impaired.</p> <p>A care plan initiated on 5/7/15, with a current goal date through 7/27/15 for Resident #43 indicated a focus of, "ADLS (Activities of Daily Living)... I am at risk for falls... Keep my call light within reach and answer it promptly ..."</p>		<p>recur: DHS/Designee will review all orders daily in the am clinical meeting and ensure care plan is updated accordingly. How the corrective measures will be monitored to ensure the alleged deficient practice does not recur: The DHS/Designee will audit new physician orders and validate care plan updates on 5 residents weekly x 5 weeks, then monthly x 5 months. The DHS /Designee will observe resident care for 5 residents weekly x 5 weeks, then monthly x 5 months to ensure resident's plan of care is consistent with the care provided. The results of the observations will be reported, reviewed and trended by the ED for compliance thru the daily Clinical Meetings. These findings will be reviewed by the QA committee quarterly for a duration of 12 months.</p>	

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	<p>On 6/30/15 at 11:45 a.m., the ED (Executive Director) provided the facility's policy, "Using the Care Plan," undated, and indicated it was the policy currently being used by the facility. The policy indicated, "... 5. Daily care and documentation must be consistent with the resident's care plan."</p> <p>2. On 6/24/2015 at 1:51 p.m., Resident #69 was observed asleep in bed. His lips and oral mucosa were dry, and pale. No water was observed at the bedside.</p> <p>6/25/2015 at 9:44 a.m., Resident #69 was observed lying in bed asleep. His lips and oral mucosa were dry, and pale and a white crusty substance was observed in the back of his throat and on his tongue. No water was observed at the bedside.</p> <p>Resident #69's clinical record was reviewed on 6/25/2015 at 10:00 a.m. Diagnoses included, but were not limited to Parkinson's disease and cardiomyopathy.</p> <p>The current Minimum Data Set (MDS) dated 5/27/2015, indicated a Brief Interview Mental Status (BIMS) score of 6, with 6 being non-interviewable with severe cognitive impairment. The current MDS further assessed Resident #69 as needing setup help with eating.</p>			

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	<p>Physician's order dated June 19, 2015 indicated, "Reduce diet from regular textures/thin liquids to mechanical soft diet excluding breads and nectar thick liquids with no straws." An order dated June 24, 2015 indicated, "Speech Therapy (ST) diet clarification order: mechanical soft diet, no breads, nectar thick liquids, no straws."</p> <p>A careplan initiated on 5/29/2015, with current goal date through 8/28/2015, for Resident #69 indicated a focus of: "... SKIN: I am at risk for dehydration related to my diagnoses and I take a diuretic medication ... Keep fresh water at my bedside ..."</p> <p>A careplan for Resident #69 initiated on 5/29/2015, with current goal date through 8/28/2015, indicated a focus of: "... BOWEL AND BLADDER: ... I want fresh drinking water at my bedside, at least, once per shift ..."</p> <p>On 6/24/2015 at 2:46 p.m., an interview with Certified Resident Care Assistant #4 (CRCA) indicated, Resident #69 currently had an order for thickened water and the Director of Nursing (DON) had told her not to leave thickened water at the bedside.</p>			

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F 0309 SS=D Bldg. 00	<p>06/24/2015 2:47 p.m., an interview with CRCA #5 indicated, Resident #69 is not allowed to have thickened water at the bedside and the residents wife was just asking the last time she was in why the resident did not have water.</p> <p>On 6/24/2015 at 2:56 p.m., an interview with the Director of Nursing indicated, Resident #69's condition changed Friday, June 19, 2015 and the speech therapist ordered thickened water after her evaluation. It is my personal policy not to leave thickened water at the bedside, because bacteria can grow at room temperature however, the care plan had not been updated and there was no order indicating water should not be left at the bedside.</p> <p>3.1-35(g)(2)</p> <p>483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. Based on observation, interview, and record review, the facility failed to ensure</p>	F 0309	Corrective actions accomplished for those residents found to be affected	07/30/2015

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	<p>a resident was accurately assessed for continuous lip smacking, tongue thrusting movements, and constant drooling for 1 of 1 random observations. (Resident #35).</p> <p>Findings include:</p> <p>On 6/22/2015 at 12:15 p.m., while speaking with the Resident #35, it was observed that she continuously smacked her lips and her tongue would protrude from her mouth. She was observed to be holding a napkin and wiping drool that was running out her mouth and down the front of her neck.</p> <p>On 6/22/2015 at 1:00 p.m., an observation of Resident #35 with the DHS (Director of Health Services) indicated she continuously smacked her lips, tongue thrusting, and drooling out of her mouth down the front of her neck.</p> <p>On 6/26/2015 at 2:00 p.m., an observation of Resident #35 indicated she was continuously lip smacking, tongue thrusting, and drooling, Resident #35 had a tissue in her hand to wipe the drool from her chin.</p> <p>The AIMS (Abnormal Involuntary Movement Scale) assessment indicated Section A. Facial and Oral Movements 2.</p>		<p>by the alleged deficient practice: Resident # 35 AIMS assessment has been updated and is accurate. A neurology consult has been scheduled.</p> <p>Identification of other residents having the potential to be affected by the same alleged deficient practice and corrective actions taken: DHS or designee will review all residents requiring AIMS assessment for accuracy.</p> <p>Measures put in place and systemic changes made to ensure the alleged deficient practice does not recur: DHS/Designee will educate Social Services Director on how to accurately complete an AIMS assessment. How the corrective measures will be monitored to ensure the alleged deficient practice does not recur: DHS/designee will conduct audits of 5 AIMS assessments per month for 12 months. These findings will be reviewed quarterly by the QA committee for a duration of 12 months.</p>	

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	<p>Lips and perioral area, e.g. puckering, pouting, smacking. rated on a scale of 0 to 4. 0=None, 1= Minimal/Normal, 2 = Mild, 3 =Moderate, 4=Severe. 4.</p> <p>Tongue Rate only increase in movement both in and out of mouth, not inability to sustain movement. The same 0-4 scale is used to rate tongue movement.</p> <p>Review of Resident #35's AIMS scale dated 4/30/2015, and 5/6/2015 indicated a score of 0 for number 2. Lips and Perioral area e.g. puckering, pouting, smacking with a score of 0=none. 4. Tongue was scored as a 0=none.</p> <p>On 6/23/2015 at 2:00 p.m., an observation of Resident #35 with the Social Services Director (SSD) indicated she was continuously smacking her lips, tongue thrusting, and drooling out of her mouth down the front of her neck. At that time, an interview with the SSD indicated she didn't access it on the AIMS (Abnormal Involuntary Movement Scale) was, because she had always done that even when she lived on the Residential side.</p> <p>On 6/23/2015 at 11:39 a.m., review of the nurses notes, progress notes, mental health wellness circumstance, assessment indicated no mention of Resident #35's continuous lip smacking, tongue thrust,</p>			

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	<p>or drooling. No update to the Abnormal involuntary movement scale (AIMS).</p> <p>Review of the medications for Resident #35 indicated a physicians order for: Xanax (anti-anxiety medication) 0.25 mg twice daily for anxiety, dated 5/12/2015. Started on 5/12/2015. Celexa (anti-depressant medication) 30 mg daily for depression, dated 4/30/2015. Started on 4/30/2015. Trazodone (anti-depressant that can be used for sleep) 25 mg at bedtime for insomnia, dated 4/30/2015. Started on 4/30/2015.</p> <p>Primary Care Phone notes dated 6/23/2015 at 3:27 p.m., from the alternate physician indicated, "With her history, it is more likely that she has a form of Parkinson's. Please advise that she needs a Neurology appointment for a second opinion." Staff felt she had exhibited these symptoms and no assessment to evaluate potential cause had been completed.</p> <p>Taber's Cyclopedic Medical Dictionary. 22nd edition, copyright 2013, tardive dyskinesia, A neurologic syndrome marked by slow, rhythmical, stereotyped movements, either generalized or in single muscle groups. These occur as an undesired effect of therapy with certain</p>			

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F 0312 SS=D Bldg. 00	<p>psychotropic drugs.</p> <p>3.1-37(a)</p> <p>483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. Based on observation, interview, and record review, the facility failed to ensure a resident received the necessary ADL (Activities of Daily Living) care in that a resident had dirt under his fingernails and around the cuticle for 1 of 1 resident randomly observed. (Resident #69).</p> <p>Findings include:</p> <p>On 6/25/2015 at 10:15 a.m., Resident #69 was observed lying in bed with a dried, dirty substance under his fingernails and around the cuticles on both hands. The substance appeared to be bowel movement (BM).</p> <p>On 6/25/2015 at 10:17 a.m., Certified Resident Care Assistant (CRCA) #3 indicated his fingers were dirty and she would get them cleaned up right away.</p>	F 0312	<p>Corrective actions accomplished for those residents found to be affected by the alleged deficient practice: Resident #69 fingernails have been cleaned and trimmed. Identification of other residents having the potential to be affected by the same alleged deficient practice and corrective actions taken: All dependant residents have been observed to ensure their nail care needs are being met. Measures put in place and systemic changes made to ensure the alleged deficient practice does not recur: DHS or designee will educate caregivers and nurses on the personal hygiene policy to include nail care. How the corrective measures will be monitored to ensure the alleged deficient practice does not recur: DHS or designee will conduct nail</p>	07/30/2015

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	<p>Resident #69's clinical record was reviewed on 6/25/2015 at 10:00 a.m. Diagnoses included, but were not limited to Parkinson's disease and Clostridium difficile (C-diff), a bacteria that attacks the lining of the intestines. Date of diagnoses for the C-diff was 6/25/2015.</p> <p>The current Minimum Data Set (MDS) dated 5/27/2015, indicated a Brief Interview Mental Status (BIMS) score of 6, with 6 being non-interviewable with severe cognitive impairment. The current MDS further assessed Resident #69 as needing two plus persons physical assist for self-performance and one person physical assist for support with personal hygiene and total dependence for bathing</p> <p>On 6/29/2015 at 12:21 p.m., Resident #69 was observed to have a trace amount of dirt under his nails and around the cuticle on his left hand.</p> <p>On 6/29/2015 at 2:37 p.m., the Director of Nursing (DON) indicated the substance could be dirt, but she wasn't sure what it was.</p> <p>On 6/29/2015 at 10:00 a.m., the DON provided the document titled, "ADL Detail Report" dated 6/25/2015, for Resident #69. The report indicated the resident received personal hygiene care at</p>		<p>hygiene audits on 3 residents per week for 3 months to ensure that nails are clean, trimmed and free of debris. These findings will be reviewed quarterly by the QA committee for a duration of 12 months.</p>		

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F 0327 SS=D Bldg. 00	<p>9:30 a.m. on 6/25/2015, with one person physical assist.</p> <p>On 6/29/2015 at 2:40 p.m., the DON provided the facility's policy, "Personal Hygiene" undated, and indicated it was the one currently being used by the facility. The policy indicated, " ...1. Hygiene tasks include but is not limited to: ... g. nail care. ... 2. Daily hygiene is provided according to the resident's care needs. ..."</p> <p>3.1-38(a)(3)(E)</p> <p>483.25(j) SUFFICIENT FLUID TO MAINTAIN HYDRATION The facility must provide each resident with sufficient fluid intake to maintain proper hydration and health. Based on observation, interview, and record review, the facility failed to ensure a resident had received the daily dietary recommended intake of fluid for 1 of 1 resident reviewed for hydration (Resident #69).</p> <p>Findings include:</p> <p>On 6/24/2015 at 1:51 p.m., Resident #69 was observed asleep in bed. His lips and mouth were dry and pale. No water was observed at the bedside. Resident #69</p>	F 0327	<p>Corrective actions accomplished for those residents found to be affected by the alleged deficient practice: 1). The hydration status and fluid needs for resident #69 were reassessed by the Registered Dietician (RD) and the Director of Health Services (DHS). Appropriate revisions were made to the care plan(s) to reflect current hydration interventions. Identification of other residents having the potential to be affected by the</p>	07/30/2015

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	<p>was making an involuntary, twitching motion while asleep.</p> <p>6/25/2015 at 9:44 a.m., Resident #69 was observed lying in bed asleep. His lips and mouth were dry, pale and a white crusty substance was observed in the back of his throat and on his tongue. No water was observed at the bedside.</p> <p>Resident #69's clinical record was reviewed on 6/25/2015 at 10:00 a.m. Diagnoses included, but were not limited to Parkinson's disease and Clostridium difficile (C-diff), a bacteria that attacks the lining of the intestines and causes watery diarrhea and fever. Date of diagnoses for the C-diff was 6/25/2015.</p> <p>The current Minimum Data Set (MDS) dated 5/27/2015, indicated a Brief Interview Mental Status (BIMS) score of 6, with 6 being non-interviewable with severe cognitive impairment. The current MDS further assessed Resident #69 as needing setup only with eating for self-performance and one person physical assist for support and none of the above for swallowing disorders.</p> <p>Physician's order dated June 2015, indicated Resident 69's medications included but, were not limited to: spironolactone-hctz (a diuretic, an agent</p>		<p>same alleged deficient practice and corrective actions taken: Residents on fluid restrictions or altered fluid consistencies have the potential to be affected. The hydration status and fluid needs for residents with risk factors were assessed by the Registered Dietician (RD) and the Director of Health Services (DHS) and appropriate revisions were made to the care plan(s) to reflect current hydration interventions.</p> <p>Measures put in place and systemic changes made to ensure the alleged deficient practice does not recur: DHS or designee will re-educate caregivers and nurses on the facility Guideline for Dehydration Risk. How the corrective measures will be monitored to ensure the alleged deficient practice does not recur: Residents that are on fluid restrictions or altered fluid consistencies will be audited by the DHS or designee weekly times 4 weeks, then monthly times 5 months to ensure compliance. These findings will be reviewed monthly by Clinical Support for 6 months for further recommendations.</p>		

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	<p>that increases urine output. Common side effects are: potassium depletion, low blood pressure, dehydration, and low blood sodium) 25-25 give 1 tablet every day for diuretic.</p> <p>A careplan initiated on 5/29/2015, with current goal date through 8/28/2015, for Resident #69 indicated a focus of: "... SKIN: I am at risk for dehydration related to my diagnoses and I take a diuretic medication. Observe my skin and mucosa during routine care. Observe me for acute mental status changes ... Keep fresh water at my bedside ..."</p> <p>A careplan for Resident #69 initiated on 5/29/2015, with current goal date through 8/28/2015, indicated a focus of: "... BOWEL AND BLADDER: ... I want fresh drinking water at my bedside, at least, once per shift ..."</p> <p>Physician's order dated June 19, 2015 indicated, "Reduce diet from regular textures/thin liquids to mechanical soft diet excluding breads and nectar thick liquids with no straws." An order dated June 24, 2015 indicated, "Speech therapy (ST) diet clarification order: mechanical soft diet, no breads, nectar thick liquids, no straws." No order noted that indicated Resident #69 should not have fluids left at bedside.</p>			

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	<p>Review of Resident #69's clinical record on 6/25/2015 indicated blood work was drawn on 6/1/2015. Sodium was 132 with a normal value of 135-145 and Potassium was 3.7 with a normal value of 3.5-5.5.</p> <p>The Nutrition Assessment and Date Collection dated 5/27/2015, indicated Resident #69's estimated fluid needs are greater than 1550 milliliters (ML) per day.</p> <p>On 6/25/2015 at 10:00 a.m., the DON provided the document titled, "Resident Intake and Output (I/O) by Day Chart" for Resident #69. The following dates indicated where Resident #69's fluid intake was below the estimated fluid need of 1550 ML per day since his admit date of 5/20/2015.</p> <p>5/21/2015=1023 ML, 5/23/2015=1203 ML, 5/24/2015=963 ML, 5/25/2015=1260 ML, 5/26/2015=1380 ML, 5/29/2015=1280 ML, 5/30/2015=1383 ML, 6/6/2015=1540 ML, 6/10/2015=1294 ML, 6/15/2015=1460 ML, 6/17/2015=1300 ML, 6/23/15=1183 ML and 6/24/2015=700 ML. Output was not recorded.</p>			

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	<p>On 6/24/2015 at 2:46 p.m., an interview with Certified Resident Care Assistant #4 (CRCA) indicated, Resident #69 currently had an order for thickened water and the Director of Nursing (DON) had told her not to leave thickened water at the bedside.</p> <p>06/24/2015 2:47 p.m., an interview with CRCA #5 indicated, Resident #69 is not allowed to have thickened water at the bedside and the resident's wife was just asking the last time she was in why the resident did not have water.</p> <p>On 6/24/2015 at 2:56 p.m., an interview with the Director of Nursing indicated, Resident #69's condition changed Friday, June 19, 2015, with increased lethargy and the speech therapist ordered thickened water after her evaluation dated 6/24/2015. It is my personal policy not to leave thickened water at the bedside, because bacteria can grow at room temperature. The facility did not have a system in place to direct staff on how Resident #69 should receive 1550 ML of fluid per day.</p> <p>On 6/25/2015 at 10:15 am., with the Director of Nursing (DON) present, Resident #69 was observed with a dry mouth, pale lips and a crusty substance in mouth. The DON indicated the resident's</p>			

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	<p>mouth was dry and she would have the CRCA use mouth moisture swabs immediately.</p> <p>On 6/25/2015 at 2:21 p.m., during an interview with the DON she indicated Resident #69 showed signs of dehydration because he had a dry mouth. The nurses should have picked up on his mouth being dry and if the resident isn't getting enough fluids the administrative staff are to talk about it in the morning meeting and come up with interventions to get fluids into the resident.</p> <p>On 6/25/2015 at 2:21 p.m., the Clinical Campus Support liaison indicated, the nurses chart by exception and a dry mouth and lips should have been an exception.</p> <p>6/25/2015 at 12:24 p.m., Resident #69 was observed on a stretcher being taken to Indiana University (IU) Health Bedford via ambulance.</p> <p>An interview at 6/25/2015 at 12:24 p.m., with License Practical Nurse (LPN) #4 indicated, Resident #69 was on his way to the emergency room with a critically low potassium level.</p> <p>A review of Resident #69's clinical record on 6/26/2015 at 9:00 a.m.,</p>			

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F 0333 SS=D Bldg. 00	<p>indicated his sodium was 134 and potassium was 2.5.</p> <p>Physician's order dated 6/25/2015 indicated, Potassium 20 meq times 1 now, send to emergency room.</p> <p>No observation of Resident #69 being offered fluids was made during the survey period.</p> <p>On 6/25/2015 at 1:20 p.m., the Administrator provided the facility's policy "Guidelines for Thickened Fluids." The policy indicated, "...6. Provide thickened liquid of choice and monitor to ensure resident's are receiving adequate hydration. (Observe skin turgor, mucous membranes, etc.) ..."</p> <p>On 6/25/2015 at 1:30 p.m., a policy on Hydration was requested and was not provided by the facility.</p> <p>3.1-46(2)(b)</p> <p>483.25(m)(2) RESIDENTS FREE OF SIGNIFICANT MED ERRORS The facility must ensure that residents are free of any significant medication errors. Based on observation, interview, and record review, the facility failed to ensure</p>	F 0333	Corrective actions accomplished for those residents found to be affected	07/30/2015

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	<p>residents were free from significant medication errors in that fast-acting insulin was given to a resident greater than 1 hour prior to getting food for 1 of 5 residents observed for medication administration observation.</p> <p>Findings include:</p> <p>On 6/29/15 at 11:14 a.m., LPN #3 was observed to draw up and administer 14 units of Humalog to Resident #116 for a blood sugar result of 382 mg/dL (milligrams per deciliter). LPN #3 indicated Resident #116 eats in her room and the hall trays are delivered after 12:00 p.m.</p> <p>On 6/29/15 at 12:28 p.m., Resident #116 was observed lying in bed without a meal tray. She indicated she felt terrible and really needed something to eat.</p> <p>On 6/29/2015 at 12:46 p.m., the hall tray arrived to Resident #116's room. The resident's hands were observed shaking and her skin was sweaty and pale in color. At this time the resident's blood sugar was tested and measured 112 mg/dL. A normal blood glucose ranges from 80-130 mg/dl.</p> <p>On 6/29/15 at 12:32 p.m., DHS (Director of Health Services) indicated Humalog</p>		<p>by the alleged deficient practice: 1). Resident #116 was assessed by nurse Praticioner and found to have adverse affects. 2) LPN #3 was educated per the facility poilicy for insulin administration. Identification of other residents having the potential to be affected by the same alleged deficient practice and corrective actions taken: All residents receiving fast acting/or sliding scale insulins have the potential to be affected. Measures put in place and systemic changes made to ensure the alleged deficient practice does not recur: DHS or designee will re-educate licensed staff on the facility policy for Insulin Administration. How the corrective measures will be monitored to ensure the alleged deficient practice does not recur: The DHS/Designee will conduct random insulin timeliness administration observations on varying shifts on 2 residents weekly x 6 weeks, then monthly x 5 months. The QAA committee will monitor for compliance quarterly x 12 month.</p>		

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	<p>should be given no sooner than 15 minutes prior to meals.</p> <p>Resident #116's clinical record was reviewed on 6/29/15 at 11:26 a.m. Diagnoses included, but were not limited to: Type 1 diabetes mellitus and diabetic ketoacidosis (a serious condition in which ketones build up in the blood and can lead to death).</p> <p>A review of Resident #116's June 2015, Physician's Orders indicated the following:</p> <p>On 6/23/15, the resident was ordered to receive Humalog subcutaneous (injected under the skin and into the fatty tissues) per a Sliding Scale (the insulin dose is based on your blood sugar level before meals), plus an additional 4 units of Humalog with each meal.</p> <p>On 6/23/15, the resident was ordered blood sugars to be tested four times daily, at 6:30 a.m., 11:30 a.m., 4:30 p.m., and at bed time.</p> <p>Resident #116's Sliding Scale for Humalog dosage was ordered as follows:</p> <p>For a blood sugar between 150-199 mg/dL, the resident was ordered 2 units of Humalog.</p>			

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	<p>For a blood sugar between 200-249 mg/dL, the resident was ordered 4 units of Humalog.</p> <p>For a blood sugar between 250-299 mg/dL, the resident was ordered 6 units of Humalog.</p> <p>For a blood sugar between 300-349 mg/dL, the resident was ordered 8 units of Humalog.</p> <p>For a blood sugar between 350-400 mg/dL, the resident was ordered 10 units of Humalog.</p> <p>If a blood sugar was greater than 400 mg/dL, the resident was ordered 12 units of Humalog and the MD (medical doctor) would be called.</p> <p>A review of Resident #116's June 2015 MAR (Medication Administration Record) indicated the resident's blood sugars ranged from 39-392mg/dL at 6:30 a.m., from 108-HI (greater that 600 mg/dL) at 11:30 a.m., from 302-502 mg/dL at 4:30 p.m., and 135-430 mg/dL at bedtime.</p> <p>The Wolters Kluwer Nursing 2014 Drug Handbook, 34th edition, copyright 2014, indicated to inject Humalog within 15 minutes before of after a meal to prevent</p>			

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F 0371 SS=F Bldg. 00	<p>a hypoglycemic (low blood sugar) reaction. Signs and symptoms of low blood sugar includes shakiness, nervousness, hunger, and sweating.</p> <p>On 6/29/15 at 2:10 p.m., the DHS provided the facility's insulin administration policy, undated, and indicated it was the one currently being used by the facility. The policy indicated, "... Humalog ... [give] 15 minutes before or immediately after meals. ..."</p> <p>3.1-48(c)(2)</p> <p>483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions Based on observation, interview, and record review, the facility failed to ensure dirty containers were not placed in the refrigerator, spilled ice cream was not left on top of the ice cream freezer, equipment was in proper working conditions, storage carts for clean pans were clean, open foods were properly labeled, expired food were discarded,</p>	F 0371	<p>Corrective actions accomplished for those residents found to be affected by the alleged deficient practice: No residents were affected. Areas identified were immediately cleaned by the Director of Food Services (DFS). The DFS removed all expired, undated, and unlabeled food items. The stove was</p>	07/30/2015

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	<p>clean backup tray carts were not sitting on the floor, food in 1 of 1 walk in refrigerator and freezer were properly labeled, and discarded when expiration date had passed, staff used proper handwashing in the kitchen, outdated food was discarded, and proper drying of equip when food will make contact, as indicated by facility policy, and Retail Food Establishment Sanitation Requirements Manual. This deficient practice had the potential to affect 51 of 51 residents being served out of the kitchen.</p> <p>Findings include:</p> <p>1). On 6/22/15 at 9:50 a.m., Dietary Aide (DA) #1 was observed to place a clean carafe of tea, tomato juice and lemonade on the floor while rearranging the reach in refrigerator. DA #1 was observed to place the carafes back into the refrigerator. DA #1 indicated the carafes should not have been placed on the floor. DA #1 was observed to remove the carafes from the refrigerator and place liquids in a clean carafe and placed the dirty carafes in the dirty dish area.</p> <p>On 6/22/15 at 9:50 a.m., the following was observed during the kitchen tour with the Dietary Manager present:</p>		<p>repaired on 7/7/15. The dishwasher was immediately reset to the correct temperature. Dietary staff were re-educated on the day shift cleaning responsibilities and evening shift cleaning responsibilities. Staff were also re-educated on food labeling and dating guidelines.</p> <p>Identification of other residents having the potential to be affected by the same alleged deficient practice and corrective actions taken: In order to prevent other residents from being affected, the Director of Food Services (DFS) or designee will audit the AM cleaning schedules, evening cleaning schedules, and perform a daily food labeling and dating audit to ensure compliance with the Trilogy guidelines for sanitation and food labeling and dating. The DFS or designee will perform an equipment inspection daily to ensure all dietary equipment is functioning properly and in accordance with manufacturer's recommendations. The DFS, or designee, will verify compliance through daily rounds of the kitchen. Measures put in place and systemic changes made to ensure the alleged deficient practice does not recur: The Director of Food Services (DFS) or designee will audit the AM cleaning schedules, evening cleaning schedules, and perform a daily food labeling and dating</p>		

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	<p>2). There was a large spill of ice cream observed on the top of the ice cream freezer in the kitchen. The Dietary Manager (DM) indicated it was not okay for the ice cream spill to be on the lid of the freezer. The DM was observed to remove the lids and give to kitchen staff to clean.</p> <p>3). There was a storage cart in the kitchen with clean metal pans observed to have spills on it and dust and dirt all over the cart. The DM was observed to remove all the pans at that time. "I will power wash."</p> <p>4). There was an open bag of chips observed on the cart with no open dated, 2 packs of hamburger buns observed with mold on them. There were 2 loaves of bread observed with mold on them. There was a pack of hotdog buns, and 2 loaves of bread open with no open date. The DM indicated he relied on the Bread man to rotate the bread. "Staff checks as they use the bread." The DM was observed to remove bread at that time, and the bag potato chips.</p> <p>5). The overflow storage room was observed to have a metal backup tray kit on the floor. The DM indicated the cart should not have been on the floor. The DM was observed to pick the cart off the</p>		<p>audit to ensure compliance with the Trilogy guidelines for sanitation and food labeling and dating. The DFS or designee will perform an equipment inspection daily to ensure all dietary equipment is functioning properly and in accordance with manufacturer's recommendations. The DFS, or designee, will verify compliance through daily rounds of the kitchen. The findings of these rounds will be documented daily and results presented at the campus QA Committee meeting.</p> <p>How the corrective measures will be monitored to ensure the alleged deficient practice does not recur: The DFS or designee will present the results of the audits and rounds at the Campus Quality Assurance meeting monthly for three months at which time the QA committee will recommend continuation or revisions to the audit process.</p>	

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	<p>floor and place it in a larger cart.</p> <p>6). On a shelf in the kitchen the following was observed:</p> <p>Three plastic container of Cheerio's. One with a broke lid was observed open with no open date. Three plastic containers of Rice Krispie were observed in a plastic container with no open date. Two plastic containers of Raisin Bran was observed on the shelf with no open date. One plastic container of Corn Flakes was observed with no open date, An open bag of Fritos no open date nor expiration date.</p> <p>7). In the walk in refrigerator the following was observed:</p> <p>Two containers with tomato paste with a storage date of 6/11/15.</p> <p>Two pans of salad dressing with no storage date on them and a container of cottage cheese open with no open or use by date.</p> <p>There were six cartons of thawed orange juice with a freezer date of 2/11/14, but no thaw date. The DM indicated he was not aware of when the juice was placed in the refrigerator to thaw. One orange juice was open, without an open date.</p>			

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	<p>On 6/25/15 at 3:14 p.m., the Executive Director indicated there was no documentation available which indicated when orange juice should be used after thawed in the refrigerator .</p> <p>There was a case of 40 Tru Moo milk with an expiration date of 6/20/15, observed on the shelf. The DM indicated, "That should go away [meaning the expired milk].</p> <p>There was a plastic bowl with peeled boiled eggs with a storage date of 6/16/15.</p> <p>There were 12 plastic tubs of strawberry low fat yogurt with a used by date of 6/19/15, and 1 tub of chicken salad with an expiration date of 6/22/15. Observed the DM to instruct DA #1 to discard the expired food. The DM indicated the chicken salad was not being served today. The DM indicated leftover food stored in the refrigerator had a shelf life of 3 days.</p> <p>8). On 6/24/15 at 11:25 a.m., the Dietary Manager was observed to dry the puree pot with a paper towel before using. The DM indicated he was not aware a wet pot could not be dried with a paper towel. The DM indicated he did not have a Retail Food Establishment and Sanitation</p>			

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	<p>Manual at that time. The DM was not aware of the Retail Food Establishment and Sanitation Manual.</p> <p>9). On 6/26/15 at 11:03 a.m., observed cook #1 to hand wash for 10 seconds and place the puree pot into the dishwasher. Cook #1 indicated she should handwash for 20 seconds. Cook #1 was observed to place fried fish in the puree pot with standing water inside. Cook #1 indicated the dish water probably should not be in the pot with the food.</p> <p>10). On 6/26/15 at 11:10 a.m., the following was observed on the shelf in the kitchen:</p> <p>An open spice container with the received date of 2/2007, and no open date.</p> <p>Five different herb containers open with the received date of 7/2012, and no open date.</p> <p>A herb container open with a received date of 3/2013, and no open date.</p> <p>A herb container open with a received date of 7/2010, and no open date.</p> <p>The Dietary Manager indicated the shelf life of herbs and spices was 2 years.</p>			

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	<p>11). On 6/26/15 at 11:30 a.m., the following was observed in the walk in freezer"</p> <p>An open bag with unidentifiable pastry without an open date nor label indicating the food item. The Dietary Manager indicated the item was cherry turnover. An open bag of onion rings without an open date.</p> <p>12). On 6/23/15 at 2:03 p.m., an interview with Resident #42's friend indicated the glasses are always dirty in the dining room. She indicated the glassware had film on them and dried food particles.</p> <p>On 6/26/15 at 3:00 p.m., with the Dietary Manager (DM) present observed 4 glassware to have spots, dry particles covering them and 1 glass had dried milk rings on the glass. The DM indicated we have had that problem before and we emptied the drain. There was no more issues with the glasses.</p> <p>13). On 6/30/15 at 11:45 a.m., observed DA #1 to run the dishwasher. The wash temperature reached 150 degrees Fahrenheit and the rinse temperature reached 160 degrees Fahrenheit. DA #1 indicated the wash temperature should have been 150 degrees Fahrenheit and the</p>			

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	<p>rinse temperature should have been 180 degrees Fahrenheit. DA #1 indicated if dishmachine was not getting up to the proper temperature she was to notify maintenance.</p> <p>On 6/30/15 at 11:50 a.m., Cook #2 indicated if the temperatures were not accurate the manufacturer would be call. Cook #2 indicated the sheet from corporate indicated the wash temperature should be 150 degrees Fahrenheit and the rinse temperature should be 180 degrees Fahrenheit.</p> <p>The dietary staff was not aware of the manufactures guideline for the wash and rinse temperature. There was a metal plate observed on the side of the dishmachine indicating the minimum wash temperature should be 155 degrees Fahrenheit, and the minimum rinse temperature should be 180 degrees Fahrenheit.</p> <p>14). On 6/30/15 at 12:00 p.m., Cook #2 provided the facilities daily data sheet for the dish machine temperatures indicated the following:</p> <p>4/1/15 the wash temperature was 151 degrees Fahrenheit.</p> <p>4/4/15 the wash temperature was 151</p>			

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	degrees Fahrenheit. 4/6/15 the wash temperature was 151 degrees Fahrenheit. 4/7/15 the wash temperature was 154 degrees Fahrenheit. 4/10/15 the wash temperature was 151 degrees Fahrenheit. 4/12/15 the wash temperature was 151 degrees Fahrenheit. 4/16/15 the wash temperature was 151 degrees Fahrenheit and noon meal wash temp was 153 degrees Fahrenheit. 4/19/15 the wash temperature was 151 degrees Fahrenheit. 4/20/15 the wash temperature was 151 degrees Fahrenheit. 4/21/15 the wash temperature was 151 degrees Fahrenheit. 4/22/15 the wash temperature was 151 degrees Fahrenheit. 4/23/14 the wash temperature was 151 degrees Fahrenheit. 4/24/15 the wash temperature was 151			

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	degrees Fahrenheit. 4/25/15 the wash temperature was 151 degrees Fahrenheit. 4/28/15 the wash temperature was 151 degrees Fahrenheit. 4/29/15 the wash temperature was 151 degrees Fahrenheit. 4/30/15 the wash temperature was 151 degrees Fahrenheit. 5/2/15 the wash temperature was 152 degrees Fahrenheit and the evening meal wash temperature was 152 degrees Fahrenheit. 5/2/15 the wash temperature was 153 degrees Fahrenheit and noon meal wash temp was 153 degrees Fahrenheit. 5/3/15 /2/15 the wash temperature was 152 degrees Fahrenheit noon meal wash temp was 154 degrees Fahrenheit. 5/4/15 the wash temperature was 152 degrees Fahrenheit. 5/5/15 5/4/15 /2/15 the wash temperature was 152 degrees Fahrenheit. 5/6/15 the wash temperature was 153			

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	degrees Fahrenheit noon meal wash temp was 153 degrees Fahrenheit. 5/7/15 the wash temperature was 151 degrees Fahrenheit noon meal wash temp was 154 degrees Fahrenheit. 5/8/15 5/3/15 /2/15 the wash temperature was 152 degrees Fahrenheit noon meal wash temp was 153 degrees Fahrenheit and evening meal wash temp was 154 degree Fahrenheit. 5/9/15 the wash temperature was 153 degrees Fahrenheit. 5/10/15 the wash temperature was 152 degrees Fahrenheit. 5/11/15 the wash temperature was 151 degrees Fahrenheit. 5/12/15 the wash temperature was 153 degrees Fahrenheit. 5/13/15 the wash temperature was 153 degrees Fahrenheit. 5/14/15 the wash temperature was 152 degrees Fahrenheit and the noon meal wash temp was 154 degrees Fahrenheit. 5/15/15 the wash temperature was 152 degrees Fahrenheit.			

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	5/16/15 the wash temperature was 153 degrees Fahrenheit.			
	5/17/15 the wash temperature was 152 degrees Fahrenheit.			
	5/18/15 the wash temperature was 153 degrees Fahrenheit.			
	5/19/15 the wash temperature was 153 degrees Fahrenheit.			
	5/20/15 the wash temperature was 151 degrees Fahrenheit.			
	5/21/15 the wash temperature was 151 degrees Fahrenheit and the evening meal wash temp was 153 degrees Fahrenheit.			
	5/23/15 the wash temperature was 151 degrees Fahrenheit, the noon meal wash temp was 153 degrees Fahrenheit and the evening meal wash temp was 154 degrees Fahrenheit.			
	5/24/15 the wash temperature was 151 degrees Fahrenheit and the noon meal wash temp was 153 degrees Fahrenheit.			
	5/25/15 the wash temperature was 151 degrees Fahrenheit.			
	5/26/15 the wash temperature was 151			

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	<p>degrees Fahrenheit and the noon meal wash temp was 153 degrees Fahrenheit.</p> <p>5/27/15 the wash temperature was 153 degrees Fahrenheit.</p> <p>5/28/15 the wash temperature was 151 degrees Fahrenheit, the noon meal wash temp was 151 degrees Fahrenheit and the evening meal wash temp was 151 degrees Fahrenheit.</p> <p>5/29/15 the wash temperature was 151 degrees Fahrenheit, the noon meal wash temp was 151 degrees Fahrenheit.</p> <p>5/30/15 the wash temperature was 153 degrees Fahrenheit.</p> <p>5/31/15 the wash temperature was 153 degrees Fahrenheit, the noon meal wash temp was 153 degrees Fahrenheit.</p> <p>6/1/15 the wash temperature was 151 degrees Fahrenheit, the noon meal wash temp was 153 degrees Fahrenheit and the evening meal wash temp was 151 degrees Fahrenheit.</p> <p>6/2/15 the wash temperature was 151 degrees Fahrenheit, the noon meal wash temp was 153 degrees Fahrenheit.</p> <p>6/3/15 the wash temperature was 151</p>			

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>degrees Fahrenheit, the noon meal wash temp was 153 degrees Fahrenheit.</p> <p>6/4/15 the wash temperature was 151 degrees Fahrenheit, the noon meal wash temp was 152 degrees Fahrenheit.</p> <p>6/6/15 the evening meal wash temp was 153 degrees Fahrenheit.</p> <p>6/8/15 the wash temperature was 151 degrees Fahrenheit, the noon meal wash temp was 153 degrees Fahrenheit.</p> <p>6/9/15 the wash temperature was 151 degrees Fahrenheit, the noon meal wash temp was 153 degrees Fahrenheit.</p> <p>6/10/15 the wash temperature was 151 degrees Fahrenheit, the noon meal wash temp was 153 degrees Fahrenheit.</p> <p>6/11/15 the wash temperature was 151 degrees Fahrenheit, the noon meal wash temp was 153 degrees Fahrenheit.</p> <p>6/13/15 the evening meal wash temp was 153 degrees Fahrenheit. There was no documentation for breakfast nor noon meal.</p> <p>6/14/15 the wash temperature was 151 degrees Fahrenheit.</p> <p>6/15/15 the wash temperature was 151</p>			

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	degrees Fahrenheit, the noon meal wash temp was 152 degrees Fahrenheit. 6/16/15 the wash temperature was 152 degrees Fahrenheit, the noon meal wash temp was 151 degrees Fahrenheit. 6/17/15 the wash temperature was 151 degrees Fahrenheit, the noon meal wash temp was 153 degrees Fahrenheit. 6/18/15 the wash temperature was 151 degrees Fahrenheit, the noon meal wash temp was 153 degrees Fahrenheit. 6/19/15 the wash temperature was 151 degrees Fahrenheit, the noon meal wash temp was 153 degrees Fahrenheit. 6/20/15 the wash temperature was 151 degrees Fahrenheit, the noon meal wash temp was 153 degrees Fahrenheit and the evening meal wash temp was 153 degrees Fahrenheit. 6/21/15 the wash temperature was 151 degrees Fahrenheit, the noon meal wash temp was 151 degrees Fahrenheit. 6/22/15 the wash temperature was 151 degrees Fahrenheit, the noon meal wash temp was 153 degrees Fahrenheit. 6/23/15 the wash temperature was 151			

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	<p>degrees Fahrenheit, the noon meal wash temp was 153 degrees Fahrenheit and the evening meal wash temp was 153 degrees Fahrenheit</p> <p>6/24/15 the wash temperature was 151 degrees Fahrenheit, There was no documented noon wash temp.</p> <p>6/25/15 the wash temperature was 151 degrees Fahrenheit, the noon meal wash temp was 153 degrees Fahrenheit and the evening meal wash temp was 154 degrees Fahrenheit.</p> <p>6/26/15 the wash temperature was 151 degrees Fahrenheit, the evening meal wash temp was 151 degrees Fahrenheit.</p> <p>6/28/15 the wash temperature was 151 degrees Fahrenheit, the noon meal wash temp was 153 degrees Fahrenheit.</p> <p>6/29/15 the wash temperature was 151 degrees Fahrenheit, the noon meal wash temp was 152 degrees Fahrenheit.</p> <p>On 6/30/15 at 12:18 p.m., the Executive Director indicated, the staff was reading the thermometer incorrectly.</p> <p>15). On 6/30/15 at 10:30 a.m., observed the popcorn machine in the activity room to have the scoop lying inside the</p>			

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	<p>machine on top of some popcorn.</p> <p>On 6/24/15 at 12:05 p.m., the Dietary Manager provided policy, "Equipment and utensils; air drying required:" undated, and indicated the policy was the one currently used by the facility. The policy indicated, "... (a) After cleaning and sanitizing, equipment and utensils: (1) shall be air-dried ... before contact with food; and (2) may not be cloth-dried except that utensils that have been air-dried may be polished, ..."</p> <p>Review of the "RETAIL FOOD ESTABLISHMENT SANITATION REQUIREMENT Manual 410 IAC 7-24," dated November 13, 2004, indicated, "Hand cleaning and drying procedure ... (a) Food employees shall, except as specified in section 343 (c) of this rule, clean their hands and exposed portions of their arms with a cleaning compound at a hand washing sink that is equipped as specified by vigorously rubbing together the surfaces of their lathered hands and arms for at least twenty (20) seconds in water ... When to wash hands (a) Food employees shall clean their hands and exposed portions of their arms as specified ... immediately before engaging in food preparation. ... and the following... (6) After handling soiled surfaces, equipment, or utensils ..."</p>			

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	<p>after engaging in other activities that contaminate the hands."</p> <p>Review of the "RETAIL FOOD ESTABLISHMENT SANITATION REQUIREMENT Manual 410 IAC 7-24-304, dated November 13, 2004, indicated, "Equipment and utensils; air drying required, ... (a) After cleaning and sanitizing, equipment and utensils:(1) shall be air-dried or used after adequate draining as specified in the 21 CFR 178.1010(a), before contact with food; and (2) may not be cloth-dried except the utensils that have been air-dried may be polished with cloths that are maintained clean and dry. ... "</p> <p>On 6/25/15 at 9:54 a.m., the Executive Director provided policy "Storage Procedure" dated 2009, and indicated the policy was the one currently used by the facility. The policy indicated, " ...DRY STORAGE OF FOOD" ...3. All shelves and storage racks ... are at least six [6] inches above the floor, ... 6. Open packages are labeled, dated, and sorted in closed containers. 7. Dry bulk foods are stored in plastic container with tight covers... Containers are clearly labeled and scoops are stored separately in a covered, protected area, ...8. Stock is dated and rotates so that the oldest items are used first.... 7. Prepared perishables</p>			

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	<p>such as salads, puddings, milk, etc., are stored in a refrigerator and covered, labeled, and dated until used. ...10. Leftovers are refrigerated immediately and used within 72 hours or frozen. ... FROZEN STORAGE: ... All foods in the freezer are wrapped, ... items are labeled and dated. ... "</p> <p>On 6/25/15 at 9:54 a.m., the Executive Director provided policy "Leftover Food Storage" undated, and indicated the policy was the one currently used by the facility. The policy indicated, "...2. Date all food and use or discard within three days. ..."</p> <p>On 6/25/15 at 9:54 a.m., the Executive Director provided policy "Dishmachine Guideline" dated 4/25/13, and indicated, the policy was the one currently used by the facility. The policy indicated, ... High Temp-Wash temp should be 150-160 degrees Fahrenheit; Rinse temp should be 180-185 degrees Fahrenheit, ... Manager in Charge Dishes will be checked for cleanliness when unloading, ... Have the dishmachine representative check the machine monthly to ensure proper operation and leave a service report. ...Conduct inservices, as needed. "</p> <p>On 6/25/15 at 9:54 a.m., the Executive Director provided policy "FOOD</p>			

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	<p>IDENTIFICATION AND STORAGE" undated, and indicated, the policy was the one currently used by the facility. The policy indicated, " ... working containers holding food, ...that are removed from their original packages ... shall be identified with common name of the food, ..."</p> <p>On 6/25/15 at 9:54 a.m., the Executive Director provided policy "Storage Procedure" dated 2009, and indicated the policy was the one currently used by the facility. The policy indicated, " ... scoops are stored separately in a covered, protected area, ..."</p> <p>On 6/26/15 at 2:15 p.m., the Executive Director provided policy "Food Labeling Guideline" dated 4/2013, and indicated the policy was the one currently used by the facility. The policy indicated, "...Yogurt ... must be date marked at the that the original container is opened, ... will not be consumed within 24 hours, The container must be Date marked and used with in 7 days or in the best if used by date, ... Prepared Leftover food items must be discarded within 3 days, ..."</p> <p>On 6/30/15 at 12:56 p.m., the provided the manufacturers guide for the dishmachine dated 2/2010. The manufacturers guide indicated, "... The</p>			

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F 0372 SS=D Bldg. 00	<p>wash tank heater will maintain the wash water temperature at 155 degree Fahrenheit. ... The booster heater will produce a minimum of 180 degrees Fahrenheit final rinse water each cycle, ... "</p> <p>3.1-21(i)(2) 3.1-21(i)(3)</p> <p>483.35(i)(3) DISPOSE GARBAGE & REFUSE PROPERLY The facility must dispose of garbage and refuse properly. Based on observation, interview, and record review, the facility failed to ensure proper disposal of garbage as indicated by facility policy and the 410 IAC Retail Food Establishment Sanitation Requirements Manual for 1 of 2 outdoor waste dumpster's.</p> <p>Findings include:</p> <p>On 6/26/15 at 11:03 a.m., with the Dietary Manager (DM) present one outside trash dumpster was observed to have trash bags hanging out of the lid. The lid was up on one of the trash dumpsters due to being full . The DM indicated everyone is responsible for keeping the lids closed. The DM was</p>	F 0372	<p>Corrective actions accomplished for those residents found to be affected by the alleged deficient practice: No residents were affected. Staff were educated on the procedures for removing trash and placing it in the dumpsters and closing the dumpster lids. Identification of other residents having the potential to be affected by the same alleged deficient practice and corrective actions taken: In order to prevent other residents from being affected, the DPO or designee will audit the dumpsters daily to ensure refuse has been disposed of properly and that the dumpster lids are shut. Measures put in place and systemic changes made to</p>	07/30/2015

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	<p>observed to remove the trash bag and place the trash bag into the second dumpster and shut the lid.</p> <p>"RETAIL FOOD ESTABLISHMENT SANITATION REQUIREMENT Manual 410 IAC 7-24," dated November 13, 2004, indicated, ...410 IAC 7-24-385 Outside receptacles Sec. 385. (a) Receptacles and waste handling units for refuse, recyclables, and returnables used with materials containing food residue and used outside the retail food establishment shall be designed and constructed to have tight-fitting lids, doors, or covers. ...410 IAC 7-24-392 Covering receptacles Sec. 392. (a) Receptacles and waste handling units for refuse, ... shall be kept covered: ... (2) with tight-fitting lids or doors if kept outside the retail food establishment. ..."</p> <p>On 6/29/15 at 2:10 p.m. the Executive Director provided policy "Garbage and Refuse" dated 4/2009, and indicated the policy was the one currently used by the facility. The policy indicated, "... All garbage and refuse will be stored and disposed of daily in a sanitary manner according to defined procedures. ... 2. Receptacle will be maintained in good condition with ... well fitting lids. ...4. Garbage and refuse will be deposited in</p>		<p>ensure the alleged deficient practice does not recur: The DPO or designee, will audit the dumpsters daily to ensure proper removal of refuse and that the dumpster lids are secured. The results of these daily audits will be reviewed monthly at the campus QA Committee meeting. How the corrective measures will be monitored to ensure the alleged deficient practice does not recur: The DPO or designee will present the results of the audits at the Campus Quality Assurance meeting monthly for three months at which time the QA committee will recommend continuation or revisions to the audit process.</p>				

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F 0431 SS=D Bldg. 00	<p>sealed containers outside of the organization to prevent harborage and feeding of pest. ... lids kept closed.</p> <p>3.1-21(i)(5)</p> <p>483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS</p> <p>The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.</p> <p>Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.</p> <p>In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.</p> <p>The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976</p>			

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	<p>and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.</p> <p>Based on observation, interview and record review the facility failed to ensure medications were stored as the facility policy indicated for 1 of 1 random observations. (RN #1, Director of Health Services)</p> <p>Findings include:</p> <p>On 6/22/2015 at 12:20 p.m., an observation of the 300 hall medication cart indicated Resident #107's Vancomycin (antibiotic used to treat infections) in a plastic bottle inside a plastic bag. The bottle was on top of the medication cart in a container half filled with water. No ice was observed in the container. No observation of nursing staff on the hall.</p> <p>On 6/22/2015 at 12:28 p.m., an interview with the Director of Health Services indicated there should not be a resident's medication left on medication cart unattended.</p> <p>On 6/22/2015 at 12:35 p.m., an observation of the 300 hall medication cart indicated Resident #107's Vancomycin (antibiotic used to treat</p>	F 0431	<p>Corrective actions accomplished for those residents found to be affected by the alleged deficient practice: 1). The medication for resident #107 was secured and re-refrigerated immediately upon observation of improper storage.</p> <p>Identification of other residents having the potential to be affected by the same alleged deficient practice and corrective actions taken: No other residents were affected.</p> <p>Measures put in place and systemic changes made to ensure the alleged deficient practice does not recur: DHS or designee will re-educate the licensed nursing staff on the following: The campus guideline for Medication Storage. How the corrective measures will be monitored to ensure the alleged deficient practice does not recur: DHS/Designee will conduct audits of med carts and med room refrigerators 2 x week on various shifts x 6 weeks, then monthly x 5 months. The QAA committee will monitor for compliance quarterly x 12 month.</p>	07/30/2015

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	<p>infections) in a plastic bottle inside a plastic bag. The bottle was on top of the medication cart in a container half filled with water. No ice was observed in the container. When RN (Registered Nurse) #1 saw the bottle of Vancomycin in a plastic bag filled with water, she then dumped the water from the container, and new containers were brought to the medication charts. The label on the Vancomycin for Resident #107 indicated was to be refrigerated. RN #1 then placed the medication in the refrigerator.</p> <p>On 6/22/2015 at 12:40 p.m., an interview with RN #1 indicated she shouldn't have left the medication on the cart unattended.</p> <p>On 6/29/2015 at 1:47 p.m., the pharmacy consultant provided the Medication Storage in the Facility policy, dated 2/1/2010, and indicated the policy was the one currently being used by the facility. The policy indicated the following: "Policy: Medications and biologicals are stored safely, securely, and properly...The medications supply is accessible only to licensed nursing personnel, pharmacy personnel, or staff members lawfully authorized to administer medications. Procedures:</p>			

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F 0441 SS=D Bldg. 00	<p>...B. Only licensed nurses, pharmacy personnel, and those lawfully authorized to administer medication...are allowed access to medications. Medication rooms, carts, and medication supplies are locked or attended by persons with authorized access....J. Medications requiring "refrigeration" ...are kept in a refrigerator with a thermometer to allow temperature monitoring...."</p> <p>3.1-25(m)</p> <p>483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS</p> <p>The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.</p> <p>(a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections.</p> <p>(b) Preventing Spread of Infection (1) When the Infection Control Program</p>			

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	<p>determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident.</p> <p>(2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease.</p> <p>(3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>Based on observation, interview, and record review, the facility failed to ensure infection control practices were followed related to hand washing in that a Environmental Services worker left a resident's room who had Clostridium difficile (C-diff) with gloves on and with the same gloves on and no hand washing observed pushed her cart down the hall to another residents room for 1 of 1 random observations. (Environmental Service Worker #1) and a Certified Resident Care Assistant (CRCA #3) failed to wash hands for 20 seconds after taking off a dirty incontinent brief and performing perineal care (Resident #69) and Registered Nurse (RN #1) failed to wash hands after changing gloves during a dressing change and to leave a pair of scissors used for a patient positive for</p>	F 0441	<p>Corrective actions accomplished for those residents found to be affected by the alleged deficient practice: Environmental Service Worker #1 , CRCA #3 and RN#1 were educated hand sanitation, changing of gloves, and equipment cleaning per the facility policy.</p> <p>Identification of other residents having the potential to be affected by the same alleged deficient practice and corrective actions taken: All residents have the potential to be affected by the same alleged deficient practice.</p>	07/27/2015

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	<p>Clostridium difficile (C-difficile) in the residents' room (Resident #106) for 2 of 4 residents randomly observed for infection control.</p> <p>Findings include:</p> <p>1. On 6/22/2015 at 12:00 p.m., an observation of Environmental Services worker #1, who was observed to not have on a gown, but did have gloves on when she exited the room of Resident #106's room who was on isolation for Clostridium difficile (C-diff). With the same pair of gloves on she pushed the cleaning cart to the next resident's room who was not on isolation. She then changed her gloves and no hand washing was observed. Environmental Services worker #1 was observed to take the same cleaning equipment to the next room, Resident #59 who had recent surgery to amputate his foot.</p> <p>On 6/22/2015 at 4:00 p.m., an interview with the Director of Nursing indicated her expectation is that when leaving a resident's room who is on isolation that anything used for the resident's room would be changed out such as a mop head.</p> <p>On 6/22/2015 at 4:31 p.m., an interview with Environmental Services Supervisor,</p>		<p>Measures put in place and systemic changes made to ensure the alleged deficient practice does not recur: DHS or designee will re-educate staff on the following campus guideline: Infection Control and Hand Washing</p> <p>How the corrective measures will be monitored to ensure the alleged deficient practice does not recur: DHS or designee will conduct random infection control and hand washing observations on various shifts for 2 residents weekly x 6 weeks, then monthly x 5 months.</p> <p>The QAA committee will monitor for compliance quarterly x 12 month.</p>	

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	<p>indicated on a daily basis a resident's room is wiped down with a disinfectant including bed rails, window sills, bathroom fixtures sink and toilet, including the floor. They change the trash. If a resident is on isolation they use a bleach product to clean with. They put a gown when they enter the room and take the gown off before exiting the room. They remove the mop head after exiting the room and place it in a separate bag and place it on the cart. The expectation is that they would remove their gloves and gown and wash their hands before exiting the room.</p> <p>On 6/24/2015 at 10:57 a.m., an interview with Environmental Services worker #1, she indicated once finished cleaning you remove gloves and gown and place them in the trash and wash hands for 20 seconds. At that time, she indicated they use the same broom and dustpan for each room, but use a different mop head for each room. She indicated that if she comes out of room and has gloves on she should have washed her hands and sanitized the cart before continuing to another resident's room.</p> <p>"Clostridium difficile Infection Information for Patients" (February, 2015) was retrieved on 7/01/2015 from the Centers of Disease Control (CDC)</p>			

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	<p>website, the guidance included how the infection is spread. Clostridium difficile is shed in feces. Any surface, device, or material (e.g., toilets, bathing tubs, and electronic rectal thermometers) that becomes contaminated with feces may serve as a reservoir for the Clostridium difficile spores. Clostridium difficile spores are transferred to patients mainly via the hands of healthcare personnel who have touched a contaminated surface or item. Clostridium difficile can live for long periods on surfaces.</p> <p>On 6/23/2015 at 9:35 a.m., the Environmental Services Supervisor provided the Resident Room Daily Tasks policy undated, and indicated the policy was the one currently being used by the facility. The policy indicated: "Pick up all trash from cans. Restroom: Clean toilet...Clean sink....Clean hand rails. Clean shower as needed. Sweep and mop floor. Resident Room:...Dust all furniture, top of closets, and all flat surfaces. Dust over bed lights. Wipe out window wills and top of air unit. Clean bed side table....Vacuum room thoroughly...."</p> <p>On 6/22/2015 at 3:56 p.m., the Director of Health Services provided the Guidelines for Contact Precautions Policy undated, and indicated the policy</p>			

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	<p>was the one currently being used by the facility. The policy indicated the following: Purpose: To provide guidelines to prevent the spread of infectious disease organisms. Procedures:</p> <ol style="list-style-type: none"> 1. Contact Precautions is a method designed to reduce the risk of transmission of microorganisms by direct or indirect methods...b. Indirect contact transmission involves contact of a susceptible host with a contaminated intermediate object, usually inanimate, in the residents environment. 2. Contact Precautions are indicated to prevent and control nosocomial transmission of infection with any of the following:...b. Clostridium difficile.... 3. Standard Precautions such as wearing gloves, good handwashing before, after procedure and between resident should always be followed.... 5. Personal Protective Equipment: <ol style="list-style-type: none"> a....change gloves and wash hands after having direct contact with the resident, possible infective material, or potentially contaminated environmental objects and between each resident care intervention.... 11. Environmental Control:... <ol style="list-style-type: none"> d. Disinfecting of equipment and supplies will be done using facility disinfectant solution... 			

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	<p>2. On 6/25/2015 at 10:15 a.m., CRCA #3 (Certified Resident Care Assistant) was observed to remove an incontinent brief that was dirty with bowel movement (BM) and to perform perineal care on Resident #69. CRCA #3 was then observed to wash hands for 5 seconds, put on clean gloves and begin to put a clean brief on Resident #69.</p> <p>Resident #69's clinical record was reviewed on 6/25/2015 at 10:00 a.m. Diagnoses included, but were not limited to C-difficile (a bacteria that attacks the lining of the intestinal tract). Contact precautions had been initiated.</p> <p>On 6/25/2015 at 10:17 a.m., CRCA #3 indicated, you should wash hands for 30 seconds which consist of grabbing the paper towel, turning on the water, getting soap, rubbing hands up and down, grabbing a paper towel and turning the water off. CRCA #3 indicated, "I'm sorry, I did not do that."</p> <p>On 6/25/2015 at 1:20 p.m., the Administrator provided the policy, "Guideline for Handwashing/Hand Hygiene" with a review date of 8/2014, and indicated the policy was the one currently used by the facility. The policy indicated, "8. ... Wash well for 20</p>			

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	<p>seconds (ABC or Happy Birthday song.), using a rotary motion and friction ..."</p> <p>3. On 6/25/2015 at 11:42 a.m., RN #1 was observed to perform a dressing change on Resident #106 . RN #1 was observed to put on gloves and remove the old dressing from Resident #106's right leg by pulling a pair of scissors from her shirt pocket and cutting the dressing off. No handwashing was observed prior to putting on the gloves. RN #1 then took the gloves off, used a hand sanitizer, put new gloves on, cleaned the wound on the right leg and placed a new dressing of gauze and an ace type wrap.</p> <p>On 6/25/2015 at 11:50 a.m., RN #1 was then observed to take off the gloves, use a hand sanitizer, and put new gloves back on. RN #1 removed the old dressing from the left leg by cutting it off with the same pair of scissors pulled from her pocket. RN #1 removed her gloves, used a hand sanitizer, put on new gloves then placed a new gauze dressing with an ace type wrap on the left leg. RN #1 removed the old gloves, put on new gloves and rubbed lotion on both of Resident #106's arms. No hand sanitizer or hand washing was observed during this time.</p> <p>On 6/25/2015 at 12:00 p.m., RN #1 was</p>			

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	<p>observed to clean the used scissors with an alcohol pad and place back into her shirt pocket.</p> <p>Resident #106's clinical record was reviewed on 6/25/2015 at 1:00 p.m. Diagnoses included, but were not limited to C-difficile. Contact precautions had been initiated</p> <p>On 6/25/2015 at 11:42 a.m., RN #1 indicated, I should have washed my hands after using the hand sanitizer 3 times but I'm not sure. "I used the hand sanitizer about 5 times." RN #1 also indicated, Resident #106 should probably have his own scissors, "But these are mine. I use alcohol to clean them between residents."</p> <p>On 6/25/2015 at 1:20 p.m., the Administrator provided the policy, "Guideline for Handwashing/Hand Hygiene" with a review date of 8/2014, and indicated the policy was the one currently used by the facility. The policy indicated, "3.d. ... After removing gloves, worn per Standard Precautions for direct contact with excretions or secretions, mucous membranes, specimens, resident equipment, grossly soiled linen, etc...."</p> <p>On 6/25/2015 at 1:20 p.m., the Administrator provided the policy</p>			

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	<p>"General Guidelines for Dressing Changes dated December 2009, and indicated the policy was the one currently used by the facility. The policy indicated, "5. Wash hands with soap and water. 6. Put on first pair of disposable gloves. 7. Remove soiled dressing and discard in plastic bag. 8. Dispose of gloves in plastic bag. 9. Wash hands with soap and water. 10. Put on second pair of disposable gloves. ...13. If using scissors, make sure it is clean with antiseptic after contact with soiled dressings. ..."</p> <p>On 6/23/2015 at 10:00 a.m., the Administrator provided the policy, "Guidelines for Contact Precautions" undated, and indicated the policy was the one currently used by the facility. The policy indicated, "2. ... Use of soap and water, rather than alcohol based handrubs, for mechanical removal of spores from hands is recommended. ... f. ... a stethoscope, sphygmomanometer, thermometer, and scissors for care should be dedicated to individual residents and left in the room ..."</p> <p>On 3/23/2015 at 5:00 p.m., review of Center for Disease Control at www.cdc.gov/handwashing/, dated December 16, 2013 indicated, "When should you wash your hands? ... Before and after caring for someone who is sick</p>			

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F 0456 SS=D Bldg. 00	<p>... Before and after treating a cut or wound ... How should you wash your hands? Wet your hands with clean, running water (warm or cold), turn off the tap, and apply soap. Scrub your hands for at least 20 seconds. Need a timer? Hum the (Happy Birthday) song from beginning to end twice. ..."</p> <p>3.1-18(l)</p> <p>483.70(c)(2) ESSENTIAL EQUIPMENT, SAFE OPERATING CONDITION The facility must maintain all essential mechanical, electrical, and patient care equipment in safe operating condition. Based on observation, interview, and record review, the facility failed to ensure the stove was maintained in proper working condition in that the front burner on the right, the left front and rear burner was observed not to ignite when the knob was turned on for 1 of 1 stove in the kitchen and the dishmachine was not operated according to the manufacturers recommendation for 1 of 1 dishmachine observed during the kitchen tour.</p> <p>Findings include:</p> <p>On 6/22/15 at 9:50 a.m., the following was observed during the kitchen tour with the Dietary Manager (DM) present:</p>	F 0456	<p>Corrective actions accomplished for those residents found to be affected by the alleged deficient practice: No residents were affected. The stove was repaired on 7/7/15. The dishwasher was immediately reset to the manufacturer's recommendations.</p> <p>Identification of other residents having the potential to be affected by the same alleged deficient practice and corrective actions taken: In order to prevent other residents from being affected, the DFS or designee will perform a daily equipment audit to ensure that the stove and dishwasher are</p>	07/30/2015

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	<p>1). The front burner on the right was observed to not ignite and the left front and rear burner was observed not to ignite. The DM was not sure how long the burners had not been working.</p> <p>2). On 6/30/15 at 11:45 a.m. the front and rear burner on the left side of the stove were observed not to be working. Cook #1 indicated the burners have to be lit with a noodle.</p> <p>3). On 6/30/15 at 11:45 a.m., observed DA #1 to run the dishwasher. The wash temperature reached 150 degrees Fahrenheit and the rinse temperature reached 160 degrees Fahrenheit. DA #1 indicated the wash temperature should have been 150 degrees Fahrenheit and the rinse temperature should have been 180 degrees Fahrenheit. DA #1 indicated if dishmachine was not getting up to the proper temperature she was to notify maintenance.</p> <p>On 6/30/15 at 11:50 a.m., Cook #2 indicated if the temperatures were not accurate the manufacturer would be call. Cook #2 indicated the sheet from corporate indicated the wash temperature should be 150 degrees Fahrenheit and the rinse temperature should be 180 degrees Fahrenheit.</p>		<p>functioning properly and in accordance with the manufacturer's recommendations. Measures put in place and systemic changes made to ensure the alleged deficient practice does not recur: The DFS or designee will perform a daily equipment audit to ensure that the stove and dishwasher are functioning properly and in accordance with the manufacturer's recommendations. The results of these daily audits will be reviewed at the monthly campus Quality Assurance committee meeting. How the corrective measures will be monitored to ensure the alleged deficient practice does not recur: The DFS or designee will present the results of these audits and at the Campus Quality Assurance meeting monthly for three months at which time the QA committee will recommend continuation or revisions to the audit process.</p>	

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	<p>The dietary staff was not aware of the manufactures guideline for the wash and rinse temperature. There was a metal plate observed on the side of the dishmachine indicating the minimum wash temperature should be 155 degrees Fahrenheit, and the minimum rinse temperature should be 180 degrees Fahrenheit.</p> <p>4). On 6/30/15 at 12:00 p.m., Cook #2 provided the facilities daily data sheet for the dish machine temperatures indicated the following:</p> <p>4/1/15 the wash temperature was 151 degrees Fahrenheit.</p> <p>4/4/15 the wash temperature was 151 degrees Fahrenheit.</p> <p>4/6/15 the wash temperature was 151 degrees Fahrenheit.</p> <p>4/7/15 the wash temperature was 154 degrees Fahrenheit.</p> <p>4/10/15 the wash temperature was 151 degrees Fahrenheit.</p> <p>4/12/15 the wash temperature was 151 degrees Fahrenheit.</p>			

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	4/16/15 the wash temperature was 151 degrees Fahrenheit and noon meal wash temp was 153 degrees Fahrenheit.			
	4/19/15 the wash temperature was 151 degrees Fahrenheit.			
	4/20/15 the wash temperature was 151 degrees Fahrenheit.			
	4/21/15 the wash temperature was 151 degrees Fahrenheit.			
	4/22/15 the wash temperature was 151 degrees Fahrenheit.			
	4/23/14 the wash temperature was 151 degrees Fahrenheit.			
	4/24/15 the wash temperature was 151 degrees Fahrenheit.			
	4/25/15 the wash temperature was 151 degrees Fahrenheit.			
	4/28/15 the wash temperature was 151 degrees Fahrenheit.			
	4/29/15 the wash temperature was 151 degrees Fahrenheit.			
	4/30/15 the wash temperature was 151 degrees Fahrenheit.			

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	5/2/15 the wash temperature was 152 degrees Fahrenheit and the evening meal wash temperature was 152 degrees Fahrenheit.			
	5/2/15 the wash temperature was 153 degrees Fahrenheit and noon meal wash temp was 153 degrees Fahrenheit.			
	5/3/15 /2/15 the wash temperature was 152 degrees Fahrenheit noon meal wash temp was 154 degrees Fahrenheit.			
	5/4/15 the wash temperature was 152 degrees Fahrenheit.			
	5/5/15 5/4/15 /2/15 the wash temperature was 152 degrees Fahrenheit.			
	5/6/15 the wash temperature was 153 degrees Fahrenheit noon meal wash temp was 153 degrees Fahrenheit.			
	5/7/15 the wash temperature was 151 degrees Fahrenheit noon meal wash temp was 154 degrees Fahrenheit.			
	5/8/15 5/3/15 /2/15 the wash temperature was 152 degrees Fahrenheit noon meal wash temp was 153 degrees Fahrenheit and evening meal wash temp was 154 degree Fahrenheit.			
	5/9/15 the wash temperature was 153			

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	degrees Fahrenheit. 5/10/15 the wash temperature was 152 degrees Fahrenheit. 5/11/15 the wash temperature was 151 degrees Fahrenheit. 5/12/15 the wash temperature was 153 degrees Fahrenheit. 5/13/15 the wash temperature was 153 degrees Fahrenheit. 5/14/15 the wash temperature was 152 degrees Fahrenheit and the noon meal wash temp was 154 degrees Fahrenheit. 5/15/15 the wash temperature was 152 degrees Fahrenheit. 5/16/15 the wash temperature was 153 degrees Fahrenheit. 5/17/15 the wash temperature was 152 degrees Fahrenheit. 5/18/15 the wash temperature was 153 degrees Fahrenheit. 5/19/15 the wash temperature was 153 degrees Fahrenheit. 5/20/15 the wash temperature was 151			

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	<p>degrees Fahrenheit.</p> <p>5/21/15 the wash temperature was 151 degrees Fahrenheit and the evening meal wash temp was 153 degrees Fahrenheit.</p> <p>5/23/15 the wash temperature was 151 degrees Fahrenheit, the noon meal wash temp was 153 degrees Fahrenheit and the evening meal wash temp was 154 degrees Fahrenheit.</p> <p>5/24/15 the wash temperature was 151 degrees Fahrenheit and the noon meal wash temp was 153 degrees Fahrenheit.</p> <p>5/25/15 the wash temperature was 151 degrees Fahrenheit.</p> <p>5/26/15 the wash temperature was 151 degrees Fahrenheit and the noon meal wash temp was 153 degrees Fahrenheit.</p> <p>5/27/15 the wash temperature was 153 degrees Fahrenheit.</p> <p>5/28/15 the wash temperature was 151 degrees Fahrenheit, the noon meal wash temp was 151 degrees Fahrenheit and the evening meal wash temp was 151 degrees Fahrenheit.</p> <p>5/29/15 the wash temperature was 151 degrees Fahrenheit, the noon meal wash</p>			

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	<p>temp was 151 degrees Fahrenheit.</p> <p>5/30/15 the wash temperature was 153 degrees Fahrenheit.</p> <p>5/31/15 the wash temperature was 153 degrees Fahrenheit, the noon meal wash temp was 153 degrees Fahrenheit.</p> <p>6/1/15 the wash temperature was 151 degrees Fahrenheit, the noon meal wash temp was 153 degrees Fahrenheit and the evening meal wash temp was 151 degrees Fahrenheit.</p> <p>6/2/15 the wash temperature was 151 degrees Fahrenheit, the noon meal wash temp was 153 degrees Fahrenheit.</p> <p>6/3/15 the wash temperature was 151 degrees Fahrenheit, the noon meal wash temp was 153 degrees Fahrenheit.</p> <p>6/4/15 the wash temperature was 151 degrees Fahrenheit, the noon meal wash temp was 152 degrees Fahrenheit.</p> <p>6/6/15 the evening meal wash temp was 153 degrees Fahrenheit.</p> <p>6/8/15 the wash temperature was 151 degrees Fahrenheit, the noon meal wash temp was 153 degrees Fahrenheit.</p> <p>6/9/15 the wash temperature was 151</p>			

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	<p>degrees Fahrenheit, the noon meal wash temp was 153 degrees Fahrenheit.</p> <p>6/10/15 the wash temperature was 151 degrees Fahrenheit, the noon meal wash temp was 153 degrees Fahrenheit.</p> <p>6/11/15 the wash temperature was 151 degrees Fahrenheit, the noon meal wash temp was 153 degrees Fahrenheit.</p> <p>6/13/15 the evening meal wash temp was 153 degrees Fahrenheit. There was no documentation for breakfast nor noon meal.</p> <p>6/14/15 the wash temperature was 151 degrees Fahrenheit.</p> <p>6/15/15 the wash temperature was 151 degrees Fahrenheit, the noon meal wash temp was 152 degrees Fahrenheit.</p> <p>6/16/15 the wash temperature was 152 degrees Fahrenheit, the noon meal wash temp was 151 degrees Fahrenheit.</p> <p>6/17/15 the wash temperature was 151 degrees Fahrenheit, the noon meal wash temp was 153 degrees Fahrenheit.</p> <p>6/18/15 the wash temperature was 151 degrees Fahrenheit, the noon meal wash temp was 153 degrees Fahrenheit.</p>			

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	<p>6/19/15 the wash temperature was 151 degrees Fahrenheit, the noon meal wash temp was 153 degrees Fahrenheit.</p> <p>6/20/15 the wash temperature was 151 degrees Fahrenheit, the noon meal wash temp was 153 degrees Fahrenheit and the evening meal wash temp was 153 degrees Fahrenheit.</p> <p>6/21/15 the wash temperature was 151 degrees Fahrenheit, the noon meal wash temp was 151 degrees Fahrenheit.</p> <p>6/22/15 the wash temperature was 151 degrees Fahrenheit, the noon meal wash temp was 153 degrees Fahrenheit.</p> <p>6/23/15 the wash temperature was 151 degrees Fahrenheit, the noon meal wash temp was 153 degrees Fahrenheit and the evening meal wash temp was 153 degrees Fahrenheit</p> <p>6/24/15 the wash temperature was 151 degrees Fahrenheit, There was no documented noon wash temp.</p> <p>6/25/15 the wash temperature was 151 degrees Fahrenheit, the noon meal wash temp was 153 degrees Fahrenheit and the evening meal wash temp was 154 degrees Fahrenheit.</p>			

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	<p>6/26/15 the wash temperature was 151 degrees Fahrenheit, the evening meal wash temp was 151 degrees Fahrenheit.</p> <p>6/28/15 the wash temperature was 151 degrees Fahrenheit, the noon meal wash temp was 153 degrees Fahrenheit.</p> <p>6/29/15 the wash temperature was 151 degrees Fahrenheit, the noon meal wash temp was 152 degrees Fahrenheit.</p> <p>On 6/30/15 at 12:18 p.m., interview with the Executive Director indicated, the staff was reading the thermometer incorrectly.</p> <p>On 6/25/15 at 9:54 a.m., the Executive Director provided policy "Dishmachine Guideline" dated 4/25/13, and indicated, the policy was the one currently used by the facility. The policy indicated, ... High Temp-Wash temp should be 150-160 degrees Fahrenheit; Rinse temp should be 180-185 degrees Fahrenheit, ... Manager in Charge Dishes will be checked for cleanliness when unloading, ... Have the dishmachine representative check the machine monthly to ensure proper operation and leave a service report. ...Conduct inservices, as needed. "</p> <p>On 6/30/15 at 12:56 p.m., the Executive Director provided the manufacturers</p>			

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F 0520 SS=D Bldg. 00	<p>guide for the dishmachine dated 2/2010. The manufacturers guide indicated, "... The wash tank heater will maintain the wash water temperature at 155 degree Fahrenheit. ... The booster heater will produce a minimum of 180 degrees Fahrenheit final rinse water each cycle, ... "</p> <p>3.1-19(bb)</p> <p>483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS</p> <p>A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff.</p> <p>The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies.</p> <p>A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section.</p> <p>Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions.</p>			

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	<p>Based on interview and record review, the facility failed to ensure the Medical Director attended the quarterly Quality Assessment and Assurance Meeting (QAA) and failed to identify and correct the same repeated deficiency for not following the residents plan of care as the the facility policy indicated for the last 4 annual surveys.</p> <p>Findings include:</p> <p>On 6/19/2015 at 2:00 p.m., review of the Casper 3 report indicated the facility had repeated deficiencies related to following the residents careplans for the last 3 annual surveys.</p> <p>On 6/26/2015 at 8:45 a.m., an interview with the Director of Health Services (DHS) indicated she did not realize the facility had repeated deficiencies for not following the residents careplans. At that time, she indicated this was not brought up in the Quality Assessment and Assurance Meetings (QAA). The DHS indicated the Medical Director is always invited to the QAA, but has never attended since she has been employed by the facility since January 2015.</p> <p>On 6/26/2015 at 12:00 p.m., an interview with the Executive Director indicated the Medical Director had not been attending</p>	F 0520	<p>Corrective actions accomplished for those residents found to be affected by the alleged deficient practice: A meeting was held with the Medical Director regarding the regulatory requirement for his attendance at the campus Quality Assurance meetings. Identification of other residents having the potential to be affected by the same alleged deficient practice and corrective actions taken: All residents residing in the facility had the potential to be affected. A meeting was held with the Medical Director regarding the regulatory requirement for his attendance at the campus Quality Assurance meetings. . Measures put in place and systemic changes made to ensure the alleged deficient practice does not recur: The Executive Director will ensure that the Medical Director is informed in advance of the date and time of each monthly Quality Assurance meeting. In the event that the Medical Director fails to meet the regulatory requirement of quarterly attendance, the Medical Director will not be retained. How the corrective measures will be monitored to ensure the alleged deficient practice does not recur: It is the practice of this campus to develop and implement appropriate plans of action to correct identified quality</p>	07/30/2015	

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	<p>the quarterly QAA meetings. At that time, he indicated the facility has made multiple attempts to get him to attend.</p> <p>On 6/29/2015 at 2:10 p.m., the Executive Director provided the Quality Assessment and Assurance Meeting Policy, undated, and indicated the policy was the one currently being used by the facility. The policy indicated the following: Meetings: The Quality Assessment and Assurance Committee shall meet as necessary, but at least quarterly. This will ensure continuous evaluation of campus systems with the objectives of:...Preventing deviation from care processes....Correcting inappropriate care processes.</p> <p>The committee is responsible for identifying issues that necessitate action of the committee, such as issues which negatively affect the quality of care and services provided to the residents. The committee will develop and implement plans of action to correct identified quality deficiencies. Members of the QAA committee will consist of: ...10. Medical Director (quarterly)...</p> <p>Action Plans Action plans shall be developed for each</p>		<p>deficiencies. 1) The attendance of the Medical Director will be monitored by the Executive Director. 2) Identified concerns will be brought forth through the daily Clinical Meetings, Weekly CAR (Clinically At Risk) Meetings) and finally through the Monthly QAA meeting. 3) Concerns identified, will have a plan of action developed to address the concern. 4) Concerns and outcomes will be monitored monthly by the E.D. through the monthly QAA Meeting. The Assistant Divisional Vice President or designee will audit the quarterly QAA meeting minutes for twelve months.</p>	

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F 9999 Bldg. 00	<p>area identified in need of correction These action plans will be followed, communicated with appropriate staff, monitored, and reassessed for effectiveness with changes made as appropriate until compliance has been met by the QAA committee...."</p> <p>3.1-52(a)(2) 3.1-52(b)(2)</p> <p>3.1-21 FOOD (i) The facility must do the following (2) Comply with 410 IAC 7-24</p> <p>This state rule was not met as evidenced by:</p> <p>Based on observation, interview, and record review, the facility failed to ensure the Retail Food Establishment Sanitation Requirement manual was available to dietary staff.</p> <p>Findings include:</p> <p>On 6/24/15 at 11:25 a.m., the Dietary Manager (DM) was observed to dry the</p>	F 9999	<p>F9999 3.1-14 Personnel Corrective actions accomplished for those residents found to be affected by the alleged deficient practice: 1). No residents were affected. 2). There were no incidents unreported. 3). LPN #3 received training on Residents Rights and Dementia per the established Policy and Procedure.</p> <p>Identification of other residents having the potential to be affected by the same alleged deficient practice and corrective actions taken: All personel files were audited for completion by ADHS of annual Residents Rights and Dementia inservice training. Measures</p>	07/30/2015

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	<p>puree pot with a paper towel. The DM indicated he was not aware a wet pot could not be dried with a paper towel.</p> <p>On 6/24/15 at 11:30 a.m., the Dietary Manager (DM) was unaware of the Retail Food and Sanitation manual. The Dietary Manager was unable to provide the manual at that time for dietary .</p> <p>The DM indicated he did not have a Retail Food Establishment and Sanitation Manual at that time. The DM was observed to print the manual off line at that time.3.1-14(k)(1) PERSONNEL</p> <p>(k) There shall be an organized ongoing in-service education and training program planned in advance for all personnel. This training shall include, but not be limited to, the following: (1) Residents' rights (6) Care of the cognitively impaired residents.</p> <p>This State rule was not met as evidenced by:</p> <p>Based on interview and record review, the facility failed to ensure staff obtained an annual in-service on residents' rights and dementia for 1 of 5 employees reviewed for ongoing in-service education and training. (LPN #3)</p>		<p>put in place and systemic changes made to ensure the alleged deficient practice does not recur: ADHS or designee will maintain log of annual Resident's Rights and Dementia training for all employees. How the corrective measures will be monitored to ensure the alleged deficient practice does not recur: Employee in-service record audits will be conducted by the ED or designee monthly x 6 mons to ensure compliance. The findings will be reviewed quarterly by the QA committee for the duration of 12 months. Alleged Date of Compliance: July 27, 2015 F9999 3.1-21 Food Corrective actions accomplished for those residents found to be affected by the alleged deficient practice: No residents were affected. The DFS printed a copy of the Retail Food Establishment and Sanitation Manual on 6/24/15 and has it available for reference.</p> <p>Identification of other residents having the potential to be affected by the same alleged deficient practice and corrective actions taken: In order to prevent other residents from being affected, the DFS printed the Retail Food Establishment and Sanitation Manual and has it available for ready reference. Measures put in place and systemic changes made to ensure the alleged</p>	

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R 0000 Bldg. 00	<p>Findings include:</p> <p>On 6/26/15 at 5:00 p.m., a personnel record review was completed. The employee personnel records indicated the following:</p> <p>LPN (Licensed Practical Nurse) #3 began employment on 06/20/2007. Her personnel record lacked documentation which indicated she received annual education and training on residents' rights and dementia for 2014, and had not completed for 2015.</p> <p>On 6/26/2015 at 5:00 p.m., an interview with Clinical Support Staff indicated the facility does not have a policy in regard to annual in-services. At that time, she indicated the annual education had not been completed for LPN #3, for 2014 and had not been completed for 2015.</p> <p>This visit was for a State Residential Licensure Survey.</p> <p>Survey dates: June 22, 23, 24, 25, 26, 29, and 30, 2015.</p>	R 0000	<p>deficient practice does not recur: The ED or designee will ensure on a monthly basis that the DFS has the Retail Food Establishment and Sanitation Manual available for reference.</p> <p>How the corrective measures will be monitored to ensure the alleged deficient practice does not recur: The ED or designee will provide the results of the monthly audit to the QA committee monthly for three months at which time the QA committee will recommend continuation or revisions to the audit process.</p> <p>The submission of this plan of correction does not indicate an admission by Stonebridge Health Campus that the findings and allegations contained herein are an accurate and true representation of the quality of</p>		

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	<p>Facility number: 003924 Provider number: 155727 AIM number: 200472040</p> <p>Census bed type: SNF:12 SNF/NF: 39 Residential: 32 Total: 83</p> <p>Census Payor type: Medicare: 13 Medicaid: 30 Other: 8 Total: 51</p> <p>Sample: 7</p> <p>These State findings are cited in accordance with 410 IAC 16.2-5.</p>		<p>care provided to our residents of Stonebridge Health Campus. This facility recognizes its obligation to provide legally and medically necessary care and services to its residents in an economic and efficient manner. The facility hereby maintains it is in substantial compliance with the requirements of participation for comprehensive health care facilities. To this end, this plan of correction shall serve as the credible allegation of compliance of this facility. We respectfully request from the department paper compliance. It is thus submitted as a matter of statute only. All corrections have been submitted to this POC.</p>				
R 0273 Bldg. 00	<p>410 IAC 16.2-5-5.1(f) Food and Nutritional Services - Deficiency (f) All food preparation and serving areas (excluding areas in residents ' units) are maintained in accordance with state and local sanitation and safe food handling standards, including 410 IAC 7-24. Based on observation, interview, and record review, the facility failed to ensure</p>	R 0273	<p>Corrective actions accomplished for those residents found to be affected</p>	07/30/2015			

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	<p>dirty containers were not placed in the refrigerator, spilled ice cream was not left on top of the ice cream freezer, equipment was in proper working conditions, storage carts for clean pans were clean, open foods were properly labeled, expired food were discarded, clean backup tray carts were not sitting on the floor, food in 1 of 1 walk in refrigerator and freezer were properly labeled, and discarded when expiration date had passed, staff used proper handwashing in the kitchen, outdated food was discarded, and proper drying of equip when food will make contact, as indicated by facility policy, and Retail Food Establishment Sanitation Requirements Manual, and proper storage of a popcorn scoop. This deficient practice had the potential to affect 32 of 32 residents being served out of the kitchen.</p> <p>Findings include:</p> <p>1). On 6/22/15 at 9:50 a.m., Dietary Aide (DA) #1 was observed to place a clean carafe of tea, tomato juice and lemonade on the floor while rearranging the reach in refrigerator. DA #1 was observed to place the carafes back into the refrigerator. DA #1 indicated the carafes should not have been placed on the floor. DA #1 was observed to remove the</p>		<p>by the alleged deficient practice: No residents were affected. Areas identified were immediately cleaned by the Director of Food Services (DFS). The DFS removed all expired, undated, and unlabeled food items. The stove was repaired on 7/7/15. The dishwasher was immediately reset to the correct temperature. Dietary staff were re-educated on the day shift cleaning responsibilities and evening shift cleaning responsibilities. Staff were also re-educated on food labeling and dating guidelines.</p> <p>Identification of other residents having the potential to be affected by the same alleged deficient practice and corrective actions taken: In order to prevent other residents from being affected, the Director of Food Services (DFS) or designee will audit the AM cleaning schedules, evening cleaning schedules, and perform a daily food labeling and dating audit to ensure compliance with the Trilogy guidelines for sanitation and food labeling and dating. The DFS or designee will perform an equipment inspection daily to ensure all dietary equipment is functioning properly and in accordance with manufacturer's recommendations. The DFS, or designee, will verify compliance through daily rounds of the kitchen. Measures put in place</p>	

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	<p>carafes from the refrigerator and place liquids in a clean carafe and placed the dirty carafes in the dirty dish area.</p> <p>On 6/22/15 at 9:50 a.m., the following was observed during the kitchen tour with the Dietary Manager present:</p> <p>2). There was a large spill of ice cream observed on the top of the ice cream freezer in the kitchen. The Dietary Manager (DM) indicated it was not okay for the ice cream spill to be on the lid of the freezer. The DM was observed to remove the lids and give to kitchen staff to clean.</p> <p>3). There was a storage cart in the kitchen with clean metal pans observed to have spills on it and dust and dirt all over the cart. The DM was observed to remove all the pans at that time. "I will power wash."</p> <p>4). There was an open bag of chips observed on the cart with no open dated, 2 packs of hamburger buns observed with mold on them. There were 2 loaves of bread observed with mold on them. There was a pack of hotdog buns, and 2 loaves of bread open with no open date. The DM indicated he relied on the Bread man to rotate the bread. "Staff checks as they use the bread." The DM was</p>		<p>and systemic changes made to ensure the alleged deficient practice does not recur: The Director of Food Services (DFS) or designee will audit the AM cleaning schedules, evening cleaning schedules, and perform a daily food labeling and dating audit to ensure compliance with the Trilogy guidelines for sanitation and food labeling and dating. The DFS or designee will perform an equipment inspection daily to ensure all dietary equipment is functioning properly and in accordance with manufacturer's recommendations. The DFS, or designee, will verify compliance through daily rounds of the kitchen. The findings of these rounds will be documented daily and results presented at the campus QA Committee meeting.</p> <p>How the corrective measures will be monitored to ensure the alleged deficient practice does not recur: The DFS or designee will present the results of the audits and rounds at the Campus Quality Assurance meeting monthly for three months at which time the QA committee will recommend continuation or revisions to the audit process.</p>	

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	<p>observed to remove bread at that time, and the bag potato chips.</p> <p>5). The overflow storage room was observed to have a metal backup tray kit on the floor. The DM indicated the cart should not have been on the floor. The DM was observed to pick the cart off the floor and place it in a larger cart.</p> <p>6). On a shelf in the kitchen the following was observed:</p> <p>Three plastic container of Cheerio's. One with a broke lid was observed open with no open date. Three plastic containers of Rice Krispie were observed in a plastic container with no open date. Two plastic containers of Raisin Bran was observed on the shelf with no open date. One plastic container of Corn Flakes was observed with no open date, An open bag of Fritos no open date nor expiration date.</p> <p>7). In the walk in refrigerator the following was observed:</p> <p>Two containers with tomato paste with a storage date of 6/11/15.</p> <p>Two pans of salad dressing with no storage date on them and a container of cottage cheese open with no open or use</p>			

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	<p>by date.</p> <p>There were six cartons of thawed orange juice with a freezer date of 2/11/14, but no thaw date. The DM indicated he was not aware of when the juice was placed in the refrigerator to thaw. One orange juice was open, without an open date.</p> <p>On 6/25/15 at 3:14 p.m., the Executive Director indicated there was no documentation available which indicated when orange juice should be used after thawed in the refrigerator .</p> <p>There was a case of 40 Tru Moo milk with an expiration date of 6/20/15, observed on the shelf. The DM indicated, "That should go away [meaning the expired milk].</p> <p>There was a plastic bowl with peeled boiled eggs with a storage date of 6/16/15.</p> <p>There were 12 plastic tubs of strawberry low fat yogurt with a used by date of 6/19/15 and 1 tub of chicken salad with an expiration date of 6/22/15. Observed the DM to instruct DA #1 to discard the expired food. The DM indicated the chicken salad was not being served today. The DM indicated leftover food stored in the refrigerator had a shelf life of 3 days.</p>			

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	<p>8). On 6/24/15 at 11:25 a.m., the Dietary Manager was observed to dry the puree pot with a paper towel before using. The DM indicated he was not aware a wet pot could not be dried with a paper towel. The DM indicated he did not have a Retail Food Establishment and Sanitation Manual at that time. The DM was not aware of the Retail Food Establishment and Sanitation Manual.</p> <p>9). On 6/26/15 at 11:03 a.m., observed cook #1 to hand wash for 10 seconds and place the puree pot into the dishwasher. Cook #1 indicated she should handwash for 20 seconds. Cook #1 was observed to place fried fish in the puree pot with standing water inside. Cook #1 indicated the dish water probably should not be in the pot with the food.</p> <p>10). On 6/26/15 at 11:10 a.m., the following was observed on the shelf in the kitchen:</p> <p>An open spice container with the received date of 2/2007, and no open date.</p> <p>Five different herb containers open with the received date of 7/2012, and no open date.</p>			

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	<p>A herb container open with a received date of 3/2013, and no open date.</p> <p>A herb container open with a received date of 7/2010, and no open date. The Dietary Manager indicated the shelf life of herbs and spices was 2 years.</p> <p>11).On 6/26/15 at 11:30 a.m., the following was observed in the walk in freezer"</p> <p>An open bag with unidentifiable pastry inside without an open date nor label indicating the food item. The Dietary Manager indicated the item was cherry turnover. A open bag of onion rings without an open date.</p> <p>12). On 6/23/15 at 2:03 p.m., an interview with Resident #42's friend indicated the glasses are always dirty in the dining room. She indicated the glassware had film on them and dried food particles.</p> <p>On 6/26/15 at 3:00 p.m., with the Dietary Manager (DM) present observed 4 glassware to have spots, dry particles covering them and 1 glass had dried milk rings on the glass. The DM indicated we have had that problem before and we emptied the drain. There was no more issues with the glasses.</p>			

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	<p>13). On 6/30/15 at 11:45 a.m., observed DA #1 to run the dishwasher. The wash temperature reached 150 degrees Fahrenheit and the rinse temperature reached 160 degrees Fahrenheit. DA #1 indicated the wash temperature should have been 150 degrees Fahrenheit and the rinse temperature should have been 180 degrees Fahrenheit. DA #1 indicated if dishmachine was not getting up to the proper temperature she was to notify maintenance.</p> <p>On 6/30/15 at 11:50 a.m., Cook #2 indicated if the temperatures were not accurate the manufacturer would be call. Cook #2 indicated the sheet from corporate indicated the wash temperature should be 150 degrees Fahrenheit and the rinse temperature should be 180 degrees Fahrenheit.</p> <p>The dietary staff was not aware of the manufactures guideline for the wash and rinse temperature. There was a metal plate observed on the side of the dishmachine indicating the minimum wash temperature should be 155 degrees Fahrenheit, and the minimum rinse temperature should be 180 degrees Fahrenheit.</p> <p>14). On 6/30/15 at 12:00 p.m., Cook #2</p>			

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	<p>provided the facilities daily data sheet for the dish machine temperatures indicated the following:</p> <p>4/1/15 the wash temperature was 151 degrees Fahrenheit.</p> <p>4/4/15 the wash temperature was 151 degrees Fahrenheit.</p> <p>4/6/15 the wash temperature was 151 degrees Fahrenheit.</p> <p>4/7/15 the wash temperature was 154 degrees Fahrenheit.</p> <p>4/10/15 the wash temperature was 151 degrees Fahrenheit.</p> <p>4/12/15 the wash temperature was 151 degrees Fahrenheit.</p> <p>4/16/15 the wash temperature was 151 degrees Fahrenheit and noon meal wash temp was 153 degrees Fahrenheit.</p> <p>4/19/15 the wash temperature was 151 degrees Fahrenheit.</p> <p>4/20/15 the wash temperature was 151 degrees Fahrenheit.</p> <p>4/21/15 the wash temperature was 151 degrees Fahrenheit.</p>			

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	4/22/15 the wash temperature was 151 degrees Fahrenheit.			
	4/23/14 the wash temperature was 151 degrees Fahrenheit.			
	4/24/15 the wash temperature was 151 degrees Fahrenheit.			
	4/25/15 the wash temperature was 151 degrees Fahrenheit.			
	4/28/15 the wash temperature was 151 degrees Fahrenheit.			
	4/29/15 the wash temperature was 151 degrees Fahrenheit.			
	4/30/15 the wash temperature was 151 degrees Fahrenheit.			
	5/2/15 the wash temperature was 152 degrees Fahrenheit and the evening meal wash temperature was 152 degrees Fahrenheit.			
	5/2/15 the wash temperature was 153 degrees Fahrenheit and noon meal wash temp was 153 degrees Fahrenheit.			
	5/3/15 /2/15 the wash temperature was 152 degrees Fahrenheit noon meal wash temp was 154 degrees Fahrenheit.			

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	5/4/15 the wash temperature was 152 degrees Fahrenheit.			
	5/5/15 5/4/15 /2/15 the wash temperature was 152 degrees Fahrenheit.			
	5/6/15 the wash temperature was 153 degrees Fahrenheit noon meal wash temp was 153 degrees Fahrenheit.			
	5/7/15 the wash temperature was 151 degrees Fahrenheit noon meal wash temp was 154 degrees Fahrenheit.			
	5/8/15 5/3/15 /2/15 the wash temperature was 152 degrees Fahrenheit noon meal wash temp was 153 degrees Fahrenheit and evening meal wash temp was 154 degree Fahrenheit.			
	5/9/15 the wash temperature was 153 degrees Fahrenheit.			
	5/10/15 the wash temperature was 152 degrees Fahrenheit.			
	5/11/15 the wash temperature was 151 degrees Fahrenheit.			
	5/12/15 the wash temperature was 153 degrees Fahrenheit.			
	5/13/15 the wash temperature was 153			

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	<p>degrees Fahrenheit.</p> <p>5/14/15 the wash temperature was 152 degrees Fahrenheit and the noon meal wash temp was 154 degrees Fahrenheit.</p> <p>5/15/15 the wash temperature was 152 degrees Fahrenheit.</p> <p>5/16/15 the wash temperature was 153 degrees Fahrenheit.</p> <p>5/17/15 the wash temperature was 152 degrees Fahrenheit.</p> <p>5/18/15 the wash temperature was 153 degrees Fahrenheit.</p> <p>5/19/15 the wash temperature was 153 degrees Fahrenheit.</p> <p>5/20/15 the wash temperature was 151 degrees Fahrenheit.</p> <p>5/21/15 the wash temperature was 151 degrees Fahrenheit and the evening meal wash temp was 153 degrees Fahrenheit.</p> <p>5/23/15 the wash temperature was 151 degrees Fahrenheit, the noon meal wash temp was 153 degrees Fahrenheit and the evening meal wash temp was 154 degrees Fahrenheit.</p>			

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	5/24/15 the wash temperature was 151 degrees Fahrenheit and the noon meal wash temp was 153 degrees Fahrenheit.			
	5/25/15 the wash temperature was 151 degrees Fahrenheit.			
	5/26/15 the wash temperature was 151 degrees Fahrenheit and the noon meal wash temp was 153 degrees Fahrenheit.			
	5/27/15 the wash temperature was 153 degrees Fahrenheit.			
	5/28/15 the wash temperature was 151 degrees Fahrenheit, the noon meal wash temp was 151 degrees Fahrenheit and the evening meal wash temp was 151 degrees Fahrenheit.			
	5/29/15 the wash temperature was 151 degrees Fahrenheit, the noon meal wash temp was 151 degrees Fahrenheit.			
	5/30/15 the wash temperature was 153 degrees Fahrenheit.			
	5/31/15 the wash temperature was 153 degrees Fahrenheit, the noon meal wash temp was 153 degrees Fahrenheit.			
	6/1/15 the wash temperature was 151 degrees Fahrenheit, the noon meal wash temp was 153 degrees Fahrenheit and the			

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	<p>evening meal wash temp was 151 degrees Fahrenheit.</p> <p>6/2/15 the wash temperature was 151 degrees Fahrenheit, the noon meal wash temp was 153 degrees Fahrenheit.</p> <p>6/3/15 the wash temperature was 151 degrees Fahrenheit, the noon meal wash temp was 153 degrees Fahrenheit.</p> <p>6/4/15 the wash temperature was 151 degrees Fahrenheit, the noon meal wash temp was 152 degrees Fahrenheit.</p> <p>6/6/15 the evening meal wash temp was 153 degrees Fahrenheit.</p> <p>6/8/15 the wash temperature was 151 degrees Fahrenheit, the noon meal wash temp was 153 degrees Fahrenheit.</p> <p>6/9/15 the wash temperature was 151 degrees Fahrenheit, the noon meal wash temp was 153 degrees Fahrenheit.</p> <p>6/10/15 the wash temperature was 151 degrees Fahrenheit, the noon meal wash temp was 153 degrees Fahrenheit.</p> <p>6/11/15 the wash temperature was 151 degrees Fahrenheit, the noon meal wash temp was 153 degrees Fahrenheit.</p> <p>6/13/15 the evening meal wash temp was</p>			

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	<p>153 degrees Fahrenheit. There was no documentation for breakfast nor noon meal.</p> <p>6/14/15 the wash temperature was 151 degrees Fahrenheit.</p> <p>6/15/15 the wash temperature was 151 degrees Fahrenheit, the noon meal wash temp was 152 degrees Fahrenheit.</p> <p>6/16/15 the wash temperature was 152 degrees Fahrenheit, the noon meal wash temp was 151 degrees Fahrenheit.</p> <p>6/17/15 the wash temperature was 151 degrees Fahrenheit, the noon meal wash temp was 153 degrees Fahrenheit.</p> <p>6/18/15 the wash temperature was 151 degrees Fahrenheit, the noon meal wash temp was 153 degrees Fahrenheit.</p> <p>6/19/15 the wash temperature was 151 degrees Fahrenheit, the noon meal wash temp was 153 degrees Fahrenheit.</p> <p>6/20/15 the wash temperature was 151 degrees Fahrenheit, the noon meal wash temp was 153 degrees Fahrenheit and the evening meal wash temp was 153 degrees Fahrenheit.</p> <p>6/21/15 the wash temperature was 151</p>			

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	<p>degrees Fahrenheit, the noon meal wash temp was 151 degrees Fahrenheit.</p> <p>6/22/15 the wash temperature was 151 degrees Fahrenheit, the noon meal wash temp was 153 degrees Fahrenheit.</p> <p>6/23/15 the wash temperature was 151 degrees Fahrenheit, the noon meal wash temp was 153 degrees Fahrenheit and the evening meal wash temp was 153 degrees Fahrenheit</p> <p>6/24/15 the wash temperature was 151 degrees Fahrenheit, There was no documented noon wash temp.</p> <p>6/25/15 the wash temperature was 151 degrees Fahrenheit, the noon meal wash temp was 153 degrees Fahrenheit and the evening meal wash temp was 154 degrees Fahrenheit.</p> <p>6/26/15 the wash temperature was 151 degrees Fahrenheit, the evening meal wash temp was 151 degrees Fahrenheit.</p> <p>6/28/15 the wash temperature was 151 degrees Fahrenheit, the noon meal wash temp was 153 degrees Fahrenheit.</p> <p>6/29/15 the wash temperature was 151 degrees Fahrenheit, the noon meal wash temp was 152 degrees Fahrenheit.</p>			

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	<p>On 6/30/15 at 12:18 p.m., the Executive Director indicated, the staff was reading the thermometer incorrectly.</p> <p>16). On 6/30/15 at 10:30 a.m., observed the popcorn machine in the activity room to have the scoop lying inside the machine on top of some popcorn. On 6/30/15 at 10:35 a.m., observed a sign at the nursing station indicating daily popcorn from 5:00-8:00 p.m.</p> <p>On 6/30/15 at 10:35 a.m., LPN #1 indicated the popcorn machine and the activity room had not been used this morning.</p> <p>On 6/30/15 at 11:40 a.m., the Activity Director (AD) indicated there was no written policy on storing the popcorn scoop. The AD indicated the scoop should not be left in the popcorn machine and there was no policy on how to store the popcorn scoop.</p> <p>On 6/30/15 at 12:05 p.m., observed the transportation staff to clean the popcorn machine.</p> <p>On 6/24/15 at 12:05 p.m., the Dietary Manager provided policy, "Equipment and utensils; air drying required;" undated, and indicated the policy was the</p>			

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	<p>one currently used by the facility. The policy indicated, "... (a) After cleaning and sanitizing, equipment and utensils: (1) shall be air-dried ... before contact with food; and (2) may not be cloth-dried except that utensils that have been air-dried may be polished, ..."</p> <p>Review of the "RETAIL FOOD ESTABLISHMENT SANITATION REQUIREMENT Manual 410 IAC 7-24," dated November 13, 2004, indicated, "Hand cleaning and drying procedure ... (a) Food employees shall, except as specified in section 343 (c) of this rule, clean their hands and exposed portions of their arms with a cleaning compound at a hand washing sink that is equipped as specified by vigorously rubbing together the surfaces of their lathered hands and arms for at least twenty (20) seconds in water ... When to wash hands (a) Food employees shall clean their hands and exposed portions of their arms as specified ... immediately before engaging in food preparation. ... and the following... (6) After handling soiled surfaces, equipment, or utensils ... after engaging in other activities that contaminate the hands."</p> <p>Review of the "RETAIL FOOD ESTABLISHMENT SANITATION REQUIREMENT Manual 410 IAC</p>			

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NAME OF PROVIDER OR SUPPLIER STONEBRIDGE HEALTH CAMPUS	STREET ADDRESS, CITY, STATE, ZIP CODE 3100 SHAWNEE DR S BEDFORD, IN 47421
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	<p>7-24-304, dated November 13, 2004, indicated, "Equipment and utensils; air drying required, ... (a) After cleaning and sanitizing, equipment and utensils:(1) shall be air-dried or used after adequate draining as specified in the 21 CFR 178.1010(a), before contact with food; and (2) may not be cloth-dried except the utensils that have been air-dried may be polished with cloths that are maintained clean and dry. ... "</p> <p>On 6/25/15 at 9:54 a.m., the Executive Director provided policy "Storage Procedure" dated 2009, and indicated the policy was the one currently used by the facility. The policy indicated, " ...DRY STORAGE OF FOOD" ...3. All shelves and storage racks ... are at least six [6] inches above the floor, ... 6. Open packages are labeled, dated, and sorted in closed containers. 7. Dry bulk foods are stored in plastic container with tight covers... Containers are clearly labeled and scoops are stored separately in a covered, protected area, ...8. Stock is dated and rotates so that the oldest items are used first.... 7. Prepared perishables such as salads, puddings, milk, etc., are stored in a refrigerator and covered, labeled, and dated until used. ...10. Leftovers are refrigerated immediately and used within 72 hours or frozen. ... FROZEN STORAGE: ... All foods in the</p>			

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	<p>freezer are wrapped, ... items are labeled and dated. ... "</p> <p>On 6/25/15 at 9:54 a.m., the Executive Director provided policy "Leftover Food Storage" undated, and indicated the policy was the one currently used by the facility. The policy indicated, "...2. Date all food and use or discard within three days. ..."</p> <p>On 6/25/15 at 9:54 a.m., the Executive Director provided policy "Dishmachine Guideline" dated 4/25/13, and indicated, the policy was the one currently used by the facility. The policy indicated, ... High Temp-Wash temp should be 150-160 degrees Fahrenheit; Rinse temp should be 180-185 degrees Fahrenheit, ... Manager in Charge Dishes will be checked for cleanliness when unloading, ... Have the dishmachine representative check the machine monthly to ensure proper operation and leave a service report. ...Conduct inservices, as needed. "</p> <p>On 6/25/15 at 9:54 a.m., the Executive Director provided policy "FOOD IDENTIFICATION AND STORAGE" undated, and indicated, the policy was the one currently used by the facility. The policy indicated, " ... working containers holding food, ...that are removed from their original packages ...</p>			

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	<p>shall be identified with common name of the food, ..."</p> <p>On 6/25/15 at 9:54 a.m., the Executive Director provided policy "Storage Procedure" dated 2009, and indicated the policy was the one currently used by the facility. The policy indicated, "... scoops are stored separately in a covered, protected area, ..."</p> <p>On 6/26/15 at 2:15 p.m., the Executive Director provided policy "Food Labeling Guideline" dated 4/2013, and indicated the policy was the one currently used by the facility. The policy indicated, "...Yogurt ... must be date marked at the that the original container is opened, ... will not be consumed within 24 hours, The container must be Date marked and used with in 7 days or in the best if used by date, ... Prepared Leftover food items must be discarded within 3 days, ..."</p> <p>On 6/30/15 at 12:56 p.m., the provided the manufacturers guide for the dishmachine dated 2/2010. The manufacturers guide indicated, "... The wash tank heater will maintain the wash water temperature at 155 degree Fahrenheit. ... The booster heater will produce a minimum of 180 degrees Fahrenheit final rinse water each cycle, ... "</p>			

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